AN EXAMINATION OF THE ROLES OF DISTRESS, SELF-STIGMA, CAREGIVER ROLE IDENTITY, AND SELF-COMPASSION IN CLERGY HELP-SEEKING ATTITUDES

By
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Submitted to the graduate degree program in Counseling Psychology and the Graduate Faculty of the University of Kansas in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Date Defended: 2 May 2018

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Date Approved: 2 May 2018

Abstract

Clergy comprise an essential subpopulation of caregivers, providing spiritual guidance and emotional support to many community members. The intense occupational demands for clergy result in burnout and mental health concerns causing them to seek support through a variety of private and intrapersonal resources, however clergy may underutilize professional psychological services when dealing with distress. A review of literature on mental health stigma, caregiver role identity, and self-compassion provides a framework for examining clergy help-seeking attitudes and understanding its various influencers. This study examines the relationships among distress, self-stigma of help-seeking, caregiver role identity, self-compassion, and attitudes toward psychological help-seeking in a majority Christian clergy sample using a quantitative method and a descriptive correlational design. Goals of this study were to examine whether caregiver role identity and self-compassion predict levels of self-stigma and whether self-stigma predicts attitudes toward help-seeking. Results revealed rates of depression in this clergy sample that resemble previous research, and showed that the stigma associated with mental health help-seeking predicts help-seeking attitudes in clergy. Clergy self-compassion predicted self-stigma of help-seeking and was significantly associated with levels of distress, caregiver role identity, and help-seeking attitudes. Findings also revealed that caregiver role identity did not relate to clergy self-stigma in ways originally hypothesized, however caregiver role identity salience was associated with higher levels of distress in clergy. Findings from this study inform future research and practice recommendations for the field of psychology in supporting the mental health of this population, and for congregations and organizations invested in clergy mental health.

Acknowledgments

My gratitude abounds for the souls whose wisdom ushered me to, and through, this project and kept me grounded along the way. I am so grateful for my advisor, Dr. Changming Duan, whose scholarship, warm heart, and social justice advocacy always challenge and inspire me; I count myself extremely fortunate to have landed in KU's program and among her advisees. I am thankful to Dr. Tom Krieshok for his mindful approach to life and teaching that will continue to shape my work; his instruction in vocational psychology provides a valued thread in this project and in my ongoing practice. I am also thankful to Dr. Tamara Coder Mikinski for generous mentorship and excellent modeling of the balancing of practice and academia. I am grateful to Dr. Kristen Hensley, for countless impromptu advising sessions and for embodying positive psychology in her teaching and supervision. My thanks, also, to Dr. Matt Reynolds for his patient statistical advising on this dissertation, and to Dr. Ed Canda for providing a wise and welcome social work voice on my dissertation committee. And, to Dr. Doyle Sager and Dr. Zach McCall, thanks for your meticulous proofreading.

I am also grateful to the clergy, seminary faculty, and academics across the nation who contributed to this project. My thanks to my father, Rev. Dr. Doyle Sager, for his wise counsel on this topic, and to Dr. David Pooler, Dr. Ron Cook, and Rev. Dr. Ed Horstmann for helpful conversations about clergy well-being and clergy research. And, for the clergy who circulated and completed the research survey, courageously sharing of themselves, I am so thankful. I hope the completed project honors their contributions.

I must acknowledge the early influencers of my academic path, social work educators and mentors Dr. Laura Bronstein, who entrusted me with projects that developed my research skills, and Dr. Diane Wiener who encouraged my first inquiries into the intersections of religion and

psychology then lovingly planted the seed for doctoral study. I am also grateful for a string of gifted and wise clinical supervisors who helped shape my hybrid social work/psychology, scientist/practitioner identity over the last decade, and for my constant teachers − my clients.

For the throng of Sagers and Summas who raised me, I am most grateful. In particular, I am thankful for Barbara Sager − teacher, writer, and grandmother − whose journey through depression educated our family on mental illness, and whose poetry taught me to savor words and to honor suffering. I am grateful to my wise and patient mother, Janet, who was my first − and remains my best − example of empathy, and to my father, Doyle, whose intellectual curiosity and devotion to his work inspire me. I am thankful for my siblings (Tamara and Joel), siblings-in-love (Tim and Jeni), and their ornery and loveable offspring, who provided consistent encouragement, needed distractions, and occasional hilarity during this project. I must also thank my strong, sassy, and intelligent sister-friends whose sage-like voices echo in my heart and my work, despite graduate school-induced absences: Clare, Kate, Kimberly, Michala, Stephanie, Kristin, Carrie, Megan, and Jamie. Most importantly, I wish to thank my partner Zach, whose love, intellect, corny jokes, and bread-baking have sustained me through critical moments on the path toward this academic goal, and whose pursuit of socially just and mindful living challenge me to be a more compassionate human being and clinician. Lastly, thank you to the clergy whose work inspired this study, and for caregivers of all breeds who aspire to reduce human suffering: may we take good care of each other.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

Introduction

Clergy members comprise an essential sub-population of helping professionals who serve vital roles in meeting the spiritual, emotional, and religious needs of their communities. Clergy typically experience a divine calling to their work (Meek et al., 2003), which leads outsiders to assume that ministry is inherently meaningful and satisfying. However, in fulfilling their calling, clergy experience relatively high levels of distress that make them disproportionately vulnerable to occupational burnout and other psychological concerns (Knox, Virginia, Thull, & Lombardo, 2005). Clergy work requires the ability to simultaneously carry out multiple roles – administrative, teaching, guiding, counseling, and leadership – that occur in highly public and scrutinized settings (Doolittle, 2010). Additionally, clergy serve as mental health first responders, remaining on-call 24 hours a day to address the emotional and spiritual needs of communities and families in crisis, a task that requires ongoing output of their own psychological resources. This level of psychological output can sometimes exceed that for which they were trained and result in untreated secondary traumatization (Holaday, Lackey, Boucher, & Glidewell, 2001).

Among the many stressors of ministry, clergy report high levels of social isolation (Weaver, Flannelley, Flannelly, & Oppenheimer, 2003; Hill, Darling, & Raimondi, 2003), consistent and intrusive demands on their time and emotional resources (Lee, 1999), unreasonable congregational expectations and idealization (Proeschold-Bell et al., 2013; Hileman, 2008), and limited or inconsistent degrees of congregational and denominational support (Miner, 2007; Proeschold-Bell et al., 2015). When compared to other helping

professions, clergy experience burnout at levels similar to those of social workers and teachers, but worse than counselors (Adams, Hough, Proeschold-Bell, Yao, & Kolkin, 2017).

The negative impact that occupational demands have on clergy mental health has been an area of growing academic interest in the past twenty years (Frenk, Mustillo, Hooten, & Meador, 2013; Hill et al., 2003; Lee, 1999; Lee, 2007; Proeschold-Bell et al, 2011; Proeschold-Bell et al., 2013; Randall, 2007; Rosetti, 2011; Weaver, Larson, Flannelly, Stapleton, & Koenig, 2002). Research has revealed that clergy members report depression at rates higher than the general population (Knox, Virginia, Thull, & Lombardo, 2005; Brumley, 2016; Expastors.com, 2017), they struggle consistently with anxiety and stress (Proeschold-Bell et al., 2013, 2015), and they experience high levels of emotional exhaustion and depersonalization (Miner, 2007). In response to external stressors, clergy experience tremendous internal stressors, such as guilt over the inability to satisfy multiple occupational demands (Proeschold-Bell et al., 2013). Of particular concern, many clergy report that the stressors of ministry cause spiritual and theological doubts or prompt their questioning of their ministerial calling (Ellison, Fang, Flannelly, & Stickler, 2013; Proeschold-Bell et al., 2013). Clergy often equate spiritual distress with psychological distress (Guthrie & Stickley, 2008; Ellison, Roalson, Guillory, Flannelly, & Marcum, 2010), and a crisis of faith can have further detrimental effects on their psychological functioning. Ministerial burnout disproportionally impacts young clergy (Randall, 2007), resulting in fifty percent of clergy leaving the ministry within the first five years (Coles, 2002). Proeschold-Bell and colleagues (2013) summarize this predicament succinctly: clergy work poses “an occupational risk to mental health," (p. 10).

Clergy coping responses to distress vary widely. Like the broader religious population, clergy may prefer private sources of support over professional sources (Cinnirella & Loewenthal,

1999; Gupta, Szymanski, & Leong, 2011). Though they access spiritual resources, supportive peer groups, friends, and family to help them cope (Zickar, Balzer, Aziz, & Wryobeck, 2008), clergy prefer *intra*personal over *inter*personal sources of support (McMinn et al. 2005), a likely byproduct of the public nature of their work and their experience of "life in a fishbowl" (Hileman, 2008, p. 122) as church leaders. Clergy isolation also results in their feeling as if the interpersonal coping responses common among non-clergy populations are somehow off-limits to them (McMinn et al., 2005; Hill et al., 2003). Additionally, research suggests that clergy choices in coping with distress are inevitably impacted by their theological framework. The degree of theological conservatism and liberalism has been found to influence how clergy experience their distress (Miner, 2007) as well as how non-clergy, religious individuals seek help (Dain, 1992; Zellmer & Anderson-Meger, 2011).

Of the many coping options available to clergy in distress, professional psychological services remain underutilized by this population (Pietkiewicz & Bachryj, 2016). In fact, a recent survey of pastors and those formerly in the ministry revealed that although 65% reported struggles with anxiety and 71% reported burnout, only 35% reported having seen a counselor or therapist (Expastors.com, 2017). Clergy reasons for not using professional psychological services include a lack of formalized procedures for dealing with the psychological demands of the job (Berry, Francis, Rolph, & Rolph, 2012) and organizational and financial barriers to accessing services (Proeschold-Bell, 2011; Trihub, McMinn, Buhrow, & Johnson, 2010). The current study is a response to research that calls for a better understanding of the professional help-seeking of clergy, including the factors that impact that help-seeking (Isacco et al., 2014).

Mental health stigma is one factor that could be influencing the relationship of clergy distress to their attitudes about help-seeking. Mental health stigma is a considerable barrier to

professional psychological help-seeking among the general population (Corrigan, 2004; Vogel, Bitman, Hammer, & Wade, 2013) and it may also be a barrier for clergy. Qualitative research on clergy help-seeking suggests that they hold stigma-based worries with regard to seeking psychological help (Besterman-Dahan, Lind, & Crocker, 2013; Isacco et al., 2014; Pietkiewicz & Bachryi, 2016), including concern about a lack of confidentiality (McMinn et al., 2005; Trihub et al., 2010), fear of negative evaluation by church members (Hileman, 2008), and beliefs that utilization of psychological services could somehow threaten their job security (Holaday et al., 2001; Meek et al., 2003; Proeschold-Bell et al., 2011). Further, there may be other internally rooted psychological factors that are related to clergy distress and help-seeking. For example, adherence to internalized and idealized caregiving roles, a phenomenon that has been a barrier to help-seeking among other caregiving populations (Siebert & Siebert, 2007), may be a barrier for clergy as well. Additionally, the ability to have compassion for one's own suffering – or self-compassion – has been linked to reduced help-seeking stigma (Heath, Brennar, Lannon, & Vogel, 2016) and may be a psychological resource particularly accessible to clergy who practice compassion for others so generously. A brief explanation of these variables of interest follows.

Variables of Interest

Distress. The proposed project will study levels of distress in clergy. Mental health concerns are all too common in the general population, with nearly one in five Americans experiencing a mental illness within a given year (SAMHSA, 2015). Psychological distress, defined more broadly than mental illness, is any transitory or chronic emotional or psychological state that impedes one's ability to effectively cope with day-to-day activities (Changes.org, n.d.). Psychological distress need not reach clinical thresholds of mental health diagnosis to be problematic, although it often encompasses symptoms characteristic of mental health disorders,

such as depression and anxiety.

Clergy distress will be operationalized in this study as the presence of depressive symptoms. Depression symptoms have been examined consistently within research on clergy mental health, burnout, and occupational distress (Brumley, 2016; Ellison et al., 2013; Frenk et al., 2013; Miles & Proeschold-Bell, 2013; Miner, 2007; Proeschold-Bell et al., 2009, 2013, 2015). Moreover, research on clergy demonstrates they experience depressive symptoms at rates higher than the general population (Knox et al., 2005; Proeschold-Bell et al., 2013). While depression is not the only marker for clergy distress, its hallmark symptoms – such as low mood, loss of pleasure, low energy, loss of motivation, sleep disturbance, poor concentration, and feelings of worthlessness (American Psychiatric Association, 2013) – serve as a reliable marker of overall psychological functioning in clergy.

Mental health help-seeking stigma. Stigma is defined as the experience of being tainted or discounted due to some external attribute or condition (Goffman, 1963). Mental health stigma, specifically, includes commonly held beliefs among the general population or internalized personal beliefs by an individual that one who exhibits a particular mental health symptom or condition is devalued, unacceptable, or undesirable (Corrigan, 2004; Corrigan & Watson, 2002).

The broad research base on mental health stigma and help-seeking stigma informs the current study. Self-stigma of mental illness and self-stigma of help-seeking have been found to negatively impact help-seeking attitudes and intentions (Clement et al., 2015; Corrigan, 2004; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Ludwikowski, Vogel, & Armstrong, 2009; Vogel et al., 2013; Vogel, Wade, & Hackler, 2007; Zartaloudi & Madianos, 2010). A systematic review of the literature on mental health stigma established a significant negative correlation between mental health stigma and help-seeking and found that stigma is the fourth

highest barrier to psychological help-seeking (Clement et al., 2015). Corrigan and Watson (2002) delineate two types of stigma associated with mental illness and the use of psychological services: self-stigma, an internalized feeling of reduced self-worth, and public stigma, the general perception of mental illness as unacceptable. Both self- and public stigma have an impact on attitudes and beliefs about mental illness and high degrees of stigma negatively influence help-seeking behaviors (Barney, Griffiths, Jorm, & Christiansen, 2006). When examining public and self-stigma longitudinally, self-stigma serves as the more proximal variable in predicting help-seeking attitudes and intentions (Vogel et al., 2013). Therefore, it is essential to better understand the role of stigma in help-seeking, to examine moderating relationships of self-stigma with other factors (Vogel et al., 2006), and to improve interventions aimed at interrupting the impact of public stigma on help-seeking via a focus on self-stigma and the factors that influence its development.

Caregiver role identity. Caregiver role identity is the degree to which one in a caregiving role is motivated by the internal and external expectations of that caregiving role and the degree to which those expectations influence that person's behaviors (Siebert & Siebert, 2005). Role Identity Theory provides a useful framework for understanding how caregivers, such as clergy, internalize beliefs about their distress and how they in turn seek help (Pooler, 2011). Role Identity Theory suggests that behavior is motivated by the many roles that one plays and that, given a hierarchy of roles, the more salient roles have a stronger influence on one's behavior (McCall & Simmons, 1978; Siebert & Siebert, 2005). Roles are reinforced by the expectations of others as well as the expectations of the self, including who an individual thinks he/she *should* be in a particular role. Pooler (2011) posits that clergy members experience considerable role salience as caregivers. Because of the many external and internal reinforcers of

caregiving role expectations, clergy may have difficulty acknowledging personal problems or asking for help when they are having the same problems as those for whom they provide care. In these instances, the idealized image that a clergy member holds of him/herself is "at odds with the reality of their personal problems" (Siebert & Siebert, 2005, p. 205). High expectations of congregants can magnify clergy role expectations and social pressure to fit an idealized self, thus increasing clergy vulnerability to distress and prompting a disregard for their own needs for help (Pooler, 2011). Research on role identity and distress in social workers, for example, has found that strong caregiver role identity is significantly and positively correlated with psychological and occupational distress and negatively correlated with help-seeking for their personal problems (Siebert & Siebert, 2005).

Self-compassion. Self-compassion, as differentiated from compassion for others, can be defined as the ability to take a warm and accepting stance toward oneself, particularly the parts that are disliked (Neff, Rude, & Kirkpatrick, 2007). The practice of self-compassion involves three distinct components: kindness to the self when there is perceived inadequacy or suffering; recognition that experiences of pain or inadequacy are an unavoidable part of being human, and thus experienced by all human beings; and the ability to hold difficult thoughts and feelings with balanced awareness, rather than avoidance, exaggeration, or self-pity. Early research on self-compassion suggests it can have buffering effects on the role of stigma in help-seeking (Heath et al., 2016; Hilbert et al., 2015). Unlike internalized stigma, which relies upon in- and outgroup membership, self-compassion emphasizes a focus on the common experience of suffering by all of humanity. Research reveals extensive positive implications of self-compassion on psychological well-being (Neff, 2003, 2009; Neff, Kirkpatrick, & Rude, 2007; Marshall et al., 2015; Sirois, Kitner, & Hirsch, 2014; Terry & Leary, 2011; Young-Eisendrath, 2008) and strong

links exist between self-compassion and the absence of psychopathology (MacBeth & Gumley, 2012). By drawing upon rich spiritual resources, clergy demonstrate compassion in abundance for their congregants and for those in need; it is unknown, however, if clergy exercise the same kind of compassion for their own pain and suffering. High levels of guilt among clergy (Proeschold-Bell et al., 2013), coupled with studies correlating low self-compassion with less self-forgiveness and more perfectionistic self-presentation in religious individuals (Brodar, Crosskey, & Thompson, 2015), suggests that an investigation of the relationship of self-compassion to clergy distress, role identity, self-stigma, and help-seeking attitudes could be informative in supporting the mental health needs of this important population of caregivers.

Research Questions and Hypotheses

Though the research demonstrating clergy distress is robust, it fails to examine the interplay between stigma and help-seeking in the clergy population. Increased knowledge about the stigma clergy experience around seeking psychological help would inform psychological practitioners and organizational leaders who support this population and would contribute to enhanced clergy well-being, and by extension, the well-being of those they serve.

The study examines the relationships among clergy distress, self-stigma of help-seeking, role identity, self-compassion, and attitudes toward psychological help-seeking. It uses a quantitative method and a descriptive correlational design to study a population that research suggests experiences considerable levels of distress and who are likely to experience self-stigma surrounding mental health help-seeking in response to that distress. Particular goals of this study are to: (a) understand the distress and professional help-seeking attitudes for clergy, (b) test the relationships between self-stigma of seeking help and attitudes toward professional psychological help-seeking for this population, and (c) examine whether caregiver role identity

and self-compassion predict levels of self-stigma in clergy.

Data were collected via online surveys from clergy members in the U.S.A. The study sought to answer the following research questions and to test the related hypotheses.

Research Question 1: Do clergy distress, caregiver role identity, and self-compassion predict self-stigma?

Hypothesis 1a - Distress will positively correlate with and predict self-stigma after accounting for demographic variables (age, education, denomination affiliation, and years in the ministry).

This hypothesis is informed by research demonstrating that those experiencing mental health symptoms and psychological distress internalize self-stigma of mental illness (Link et al., 2001; Corrigan, 2004) and experience associated help-seeking stigma (Barney et al., 2005). The relationship between mental health symptoms and internalized stigma has been identified in the general population (Parcasepe & Cabassa, 2013) as well as in religious individuals (Eisenberg, Downs, Golberstein, & Zivin, 2009).

Hypothesis 1b – Caregiver role identity will positively correlate with and predict self-stigma above and beyond distress levels and demographic variables.

This hypothesis draws upon Role Identity Theory's conceptualization of the idealized self (McCall & Simmons, 1978), specifically that the salience of one's role identity as a caregiver can heighten a sense of outgroup membership and reduced self-esteem when one exhibits traits inconsistent with that role (Pooler, 2011), such as the distress related to mental health symptoms. Though caregiver role identity has not been studied in relationship to self-stigma, stronger caregiver role identity has been related to increased distress and a decreased tendency to seek help (Siebert & Siebert, 2005). Hypothesis 1b aims to capture Pooler's supposition about a

relationship existing between clergy's caregiver role identity and their internalized stigma.

Hypothesis 1c – Self-compassion will negatively correlate with and predict self-stigma above and beyond distress, caregiver role identity, and demographic variables.

This hypothesis builds on emergent research suggesting a relationship between self-compassion and stigma. In particular, self-compassion acts as a buffer between self-stigma and reported distress (e.g. mental health complaints, somatic concerns, and reported quality of life) (Hilbert et al., 2015) and self-compassion can lend psychological resilience for those experiencing mental health stigma (Heath et al., 2016). Furthermore, self-compassion improves one's ability to relate to oneself in times of distress (Neff, 2009), increases one's ability to transform their suffering (Young-Eisendrath, 2008), and improves self-regulation and health (Terry & Leary, 2011).

Research Question 2: Do clergy distress and self-stigma predict attitudes toward professional help-seeking?

Hypothesis 2a – Clergy distress and self-stigma will negatively correlate with and predict attitudes toward help-seeking after accounting for demographic variables (age, education, denomination affiliation, and years in the ministry).

This hypothesis is based on research suggesting that religious individuals seek private, rather than public sources of help and that this may be predicated on the belief that psychological services may not adequately account for their spiritual needs (Cinnirella & Loewenthal, 1999). Research has demonstrated that religious individuals do not endorse attitudes in favor of professional psychological help-seeking (Royal & Thompson, 2012), clergy prefer non-counseling forms of support over professional counseling (Trihub et al., 2010), and clergy underutilize professional psychological support in managing their mental health symptoms

(Pietkiewicz & Bachryj, 2016). Lastly, research shows that clergy encounter organizational barriers, such as limited time off and financial barriers to accessing professional psychological services (Proeschold-Bell, 2009; Trihub et al., 2010), and thus may be reticent to choose this form of support when dealing with distress.

Hypothesis 2b – Self-stigma of help-seeking will moderate the relationship between distress and attitudes toward professional help-seeking after accounting for demographic variables.

Self-stigma of mental illness and self-stigma of help-seeking have been found to negatively impact help-seeking attitudes and intentions (Corrigan, 2004; Clement et al., 2015; Link et al., 2001; Ludwikowski, Vogel, & Armstrong, 2009; Vogel et al., 2013; Vogel et al., 2007; Zartaloudi, 2010). In particular, one study (Lannin et al., 2015) found that while both the stigma of mental illness and the stigma of help-seeking negatively impact self-esteem, it was the self-stigma of help-seeking alone that predicted counseling intentions. Additionally, this hypothesis draws upon research on the interaction of self-stigma with public stigma and help-seeking attitudes. Self-stigma has been found to mediate the relationship between public stigma and willingness to seek counseling (Vogel et al., 2007), between public stigma and attitudes toward mental health treatment (Brown et al., 2010), and to predict the impact of public stigma on help-seeking over time (Vogel et al., 2013). Furthermore, self-stigma researchers have encouraged exploration of the moderating relationships between self-stigma and other variables, such as type of disorder and severity of symptoms (Vogel et al., 2006). Lastly, Hypothesis 2b responds to Clement and colleagues' (2015) call for attention to the help-seeking stigma occurring within specific populations.

CHAPTER 2

Review of Literature

Clergy Occupational Demands

The work of clergy members is vital to the health of communities. This population of religious leaders serves functions that extend beyond weekly sermons made in Sunday pulpits. From small rural congregations to suburban mega-churches, clergy are positioned to encounter the emotional and spiritual needs of congregants and must possess a challenging combination of occupational skills that include teaching, counseling, administrating, leading, officiating, public speaking, and spiritual advising (Francis, Hill, & Rutledge, 2008). With roughly 76% of the population in America reporting a religious affiliation (Pew Research Center, 2014), 25-40% of Americans reporting they seek counseling from clergy (Wang, Berglund, & Kessler, 2003), and nearly 40% of Americans with mental health symptoms reporting they turn to clergy *first* as a source of emotional support (Weaver, 1995), the work of clergy impacts the lives of countless community members.

Clergy work, however, is demanding. As first responders to their congregants' crises, clergy frequently function as frontline mental health workers (Weaver, 1995; Weaver et al., 2003), thus expending emotional resources and sometimes falling victim to their own untreated secondary traumatization (Holaday et al., 2001). Additionally, members of the clergy face high and idealistic expectations from their congregants (Grosch & Olsen, 2000) and withstand tremendous pressure to uphold their esteemed religious roles. Often regarded as models of religious piety, clergy's actions are scrutinized and evaluated by others, causing them to feel their lives and the lives of their family members are on display (Hileman, 2008). The resulting isolation leaves clergy feeling as if they lack safe and trusting confidants (Weaver et al., 2002).

Because clergy tend to be on-call 24 hours a day, they are on the receiving end of intrusive demands on their time and energy, with boundary ambiguity between them and congregants being the most frequently cited boundary concern (Lee, 1999). Driven to serve others by a strong sense of religious calling, clergy then negotiate the guilt related to setting healthy boundaries and may over-give at the expense of their own wellness (Isacco et al., 2014; Hill et al., 2003).

Clergy Distress

The stressors of clergy work come with a price. Long hours and work demands make clergy susceptible to the high emotional exhaustion and depersonalization characteristic of occupational burnout (Randall, 2007). In fact, clergy members report burnout at rates similar to social workers and teachers, but higher than counselors (Adams et al., 2017). For many clergy, work performance may be inseparable from their identity as a divinely called leader, making it difficult for them to tease out *who they are* from *what they do* (Barnard & Curry, 2012). Occupational failings can have detrimental effects on self-esteem and self-efficacy; when standards for performance are so high in clergy, a perceived sense of failure can be magnified if those standards are not met (Stewart-Sicking, Ciarrocchi, Hollensbe, & Sheep, 2011).

The demands from congregants comprise a consistent source of stress for clergy. Clergy have identified relational issues, ministry issues, high expectations and needs, and conflicts as most stressful in their ministries (Miner, 2007). In a study examining how intrusive demands made on clergy impact distress and well-being (Lee, 1999), clergy rated demands, such as personal criticisms, boundary ambiguity, and presumptive expectations, as strong. Each demand was significantly correlated with their well-being, burnout, satisfaction with life, and attitudes toward the ministry. In particular, the consequences of intrusive demands were more likely to be experienced in clergy's subjective sense of well-being than in their attitudes toward the ministry.

This suggests that clergy's sense of calling may prevail over self-care; in the wake of high occupational demands, clergy well-being rather than clergy commitment to their work may be the thing to suffer.

Beyond burnout and stress, the deluge of demands on clergy time and emotional resources lead to mental health symptoms, such as depression. Low vocational satisfaction among clergy predicts depression, a mental health symptom they report at rates seven times greater than the general population (Knox et al, 2005). Though rates of depression in clergy depend on the study, they are consistently and notably elevated. For example, in another study of 1,726 American Methodist Clergy, Proeschold-Bell et al. (2013) found clergy depression rates at and 11.1%, which was significantly higher than the rate of 5.5% in the general population (Pratt & Brody, 2008). A survey of current clergy and those who had left the ministry showed that 47% reported they constantly fight depression, 63% considered themselves lonely, 77% reported experiencing burnout, and only 25% reported having a close friend with whom to share their struggles (Brumley, 2016). A direct link between job stress and depression is clear; in yet another study, most clergy reported experiencing some occupational distress and this distress correlated strongly with their endorsement of depressive symptoms in the previous four weeks (Frenk et al., 2013).

The spiritual is psychological. Not surprising for those motivated by religious calling, clergy are disproportionately impacted by the spiritual unease that grows out of occupational distress. Research supports the conclusion that clergy experience mental and spiritual distress as one and the same (Guthrie & Stickley, 2008) and that a rattling of clergy's spiritual foundation through occupational distress can make them increasingly susceptible to psychological concerns (Proeschold-Bell et al, 2013). For example, in a study of stressors and coping among 1,272

ordained Presbyterian clergy, Ellison et al. (2010) found that clergy experiencing low well-being and interpersonal stressors noted regular criticisms and demands from their congregants. Spiritual struggles, however, were found to mediate the relationship between stressors and psychological functioning; clergy experiencing negative life events were more likely to experience spiritual doubt which in turn compromised their psychological functioning. Ellison et al. (2010) noted,

> Pastors who experience negative events, especially multiple stressors within a given year, are more inclined than others to encounter spiritual difficulties, coming to doubt core tenets of their faith or to feel abandoned by, and angry toward, God in the wake of these traumatic events. Indeed, this may be one way in which stressful events influence mental health outcomes. (p. 299)

Spiritual struggles may be a critical result of clergy stress and may hinder well-being by lowering confidence, threatening identity, and decreasing clergy's sense of competence.

This link between spiritual and psychological struggles has been documented in the general (non-clergy) population where a positive and significant association exists between religious struggles and beliefs and symptoms of anxiety, depression, phobia, and somatization (Ellison et al., 2013). Of particular interest to clergy research, Ellison et al. found that the magnitude of this relationship differed with how much participants identified as religious. This indicates that a strong religious identity – like that expected among clergy – might magnify the distress experienced when one's life circumstances violate this identity. Ellison and colleagues state,

> Although spiritual struggles may be detrimental to mental health for much of the population, these effects may be compounded for persons who are most steeped in

> religious teachings. For these individuals, the cognitive discordance between spiritual struggles and personal values – along with resulting shame and guilt – are likely to be most acute. (p. 217)

Clergy Coping

In the face of occupational distress and mental health symptoms, clergy cope in a variety of ways. Not surprisingly, clergy rely heavily upon spiritual resources such as prayer, support groups, and spiritual retreats (Trihub et al, 2010). In a qualitative analysis of 103 clergy responses to the question *How do you keep yourself healthy*?, sixty-nine percent of responses were classified as intrapersonal, such as time off, meditation, exercise, personal retreats, and ministry activities (McMinn et al., 2005). Clergy relied less upon interpersonal coping, with only 19% of clergy coping via therapy, group bible study, worship, and trusted friends. The tendency to utilize intrapersonal coping is a likely byproduct of the isolation and boundary intrusions clergy experience (Hill et al., 2003; McMinn et al., 2005).

Though helpful in many instances, a tendency to cope privately without inviting other supports can be assessed by some clergy as unhealthy. In additional analysis of a study of clergy who experienced sexual attraction to congregants (Meek et al., 2003), McMinn et al. (2005) used an expert panel of psychologists and clergy to distinguish healthy coping responses from unhealthy coping responses. Of the healthy responses, they further parsed these responses as relational or intrapersonal. Consistent with previously stated research, results revealed clergy were more likely to use healthy intrapersonal coping than healthy relational coping. Of particular note, they also found that clergy were more likely to use coping deemed questionable by the expert panel or deemed neither healthy nor unhealthy (such as "I distracted myself to think of someone else") than they were to use healthy relationship coping. This suggests that clergy,

particularly those experiencing emotions traditionally categorized as taboo, may choose intrapersonal coping to avoid the level of social evaluation that accompanies revealing their thoughts and emotions to others.

Despite a tendency toward intrapersonal coping, research suggests that clergy and their spouses deem social support to be important. Lee (2007) examined patterns of stress in 147 clergy families by investigating the interactions between stressors, available resources, and perceptions of ministry satisfaction among clergy and their spouses. Lee found that satisfaction with social support was the variable most highly correlated with well-being and with positive attitudes toward ministry. Denominational and congregational relationships were particularly important for respondents; the higher these resources, the higher clergy and spouses rated their well-being. When clergy do access interpersonal support, it often comes via clergy support groups. However, recent research on clergy support groups has found that the benefits of this coping strategy differ according to personal characteristics and clergy coping styles (Miles & Proeschold-Bell, 2013). Furthermore, despite using them, clergy assess these support groups as insufficient in addressing the totality of their mental health concerns.

The literature on clergy burnout provides some additional insight into their coping methods and the impact on well-being. Doolittle (2007) examined the coping strategies that accompanied occupational burnout for 222 Methodist clergy. In that study, 13% of respondents considered themselves burned out and 23% considered themselves depressed. When using coping strategies like venting, disengagement, and self-blame, clergy experienced greater emotional exhaustion and depersonalization. Coping methods of acceptance, planning, and positive reframing correlated negatively with burnout, suggesting these adaptive methods of coping may protect against occupational and emotional distress in this population. Interestingly,

a higher spirituality score among clergy correlated with greater personal accomplishment but also greater emotional exhaustion and depersonalization. This research suggests an important link between types of coping for clergy distress as well as the complex role that spirituality plays in the process of clergy coping.

Professional help-seeking. Regardless of attempts to cope, for many clergy the ongoing distress they experience outpaces their ability to manage it. Miner (2007b) reported that clergy problem solving strategies have been found to have little impact on their reported stressors. Rather than this suggesting a deficit in clergy's ability to manage their problems, it may speak to just how persistent the stressors are for this population. Research has begun to recognize the role of professional psychological counseling in supporting clergy mental health, including calling for emotion-focused coping strategies to support the clergy population (Miner, 2007b), for anonymous and non-church-affiliated support to help clergy manage the demands of ministry (Hill et al., 2003), and even for denominational and church policies that facilitate the provision and funding of professional mental health services for clergy (Trihub et al., 2010).

Some research suggests clergy underutilize professional psychological support in managing their mental health symptoms (Pietkiewicz & Bachryj, 2016). This may be because very few congregations have formal procedures to deal effectively with the psychological demands of the job (Berry et al., 2012). Additionally, clergy encounter organizational barriers, such as limited time off and financial barriers to accessing professional psychological services (Proeschold-Bell, 2009; Trihub et al., 2010). In a survey of 434 American clergy members, Trihub et al. (2010) inquired about services offered to clergy for mental health, the extent to which clergy value these services, their reported utilization of these services, and obstacles to their utilization. While 31% of responding clergy reported using individual counseling, this

service fell significantly below prayer, support groups, and time off in its reported availability. Furthermore, clergy ratings of the extent to which individual counseling was valued for their mental health (3.9 on a 5 point Likert scale) exceeded their overall rating of the degree to which this service was available to them (2.8 on a 5 point Likert scale), suggesting that accessibility of counseling could be one considerable barrier for clergy.

Not unlike the help-seeking of religious non-clergy (Worthington, 1988), the seeking of psychological help by clergy could also be influenced by their religious involvement and their values. In the broader religious population, only 39% of religious individuals seeking professional psychological help deem it a good choice when facing personal struggles (Gupta et al., 2011), and religious individuals tend to seek private, rather than public, sources of psychological help (Cinnirella & Loewenthal, 1999) even though they simultaneously assess religious interventions as inadequate (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Additionally, in a study of 540 Protestant Christian adults, Royal and Thompson (2012) found that participants did not generally endorse attitudes in favor of seeking psychological help and had mixed feelings about the effectiveness of counseling. Instead, participants exhibited a tendency to believe that most emotional problems tend to work themselves out. Of all the survey items assessing respondents' attitudes toward help-seeking, the item about believing that talking to a psychologist was a poor way of getting rid of emotional problems was the most highly endorsed by the religious population in their study. Concerns about return on investment for services and perceptions about the effectiveness of services may be reasons for this lack of willingness to utilize professional psychological services.

Conservative clergy, in particular, may prefer religious support over professional psychological services. Research has examined factors impacting help-seeking attitudes among

evangelical clergy, a subset of the clergy population whose belief systems are generally described as conservative. Salwen et al. (2017) hypothesized that spiritual well-being and tendencies toward self-disclosure would impact evangelical seminarians' attitudes toward mental health help-seeking. They found no significant relationships between self-disclosure, spiritual well-being, and attitudes toward help-seeking among their 251 American evangelical seminary students. They suggested this finding may point to other factors impacting help-seeking among clergy, such as their thoughts about the type of help-seeking that may be socially sanctioned by their religious beliefs. Salwen and colleagues write,

> It may mean that attitudes toward seeking professional psychological help have more complex origins in social and cultural factors relating to the perception of professional psychology, such as denominational alignments, individual pastoral and mentoring relationships, and exposure to a nouthetic counseling philosophy. (p. 12)

Furthermore, the authors suggest that evangelical Christians may be socialized to rely more on faith and "biblical sufficiency" (p. 14) and to dismiss professional psychology as inferior to their theologically-based solutions and thus ultimately unhelpful. While such speculation about the interaction between belief systems, spiritual well-being, and help-seeking attitudes warrants further research, it is notable that this study focused on early career pastors who were still in seminary and thus it may not capture the interaction of these variables as influenced by the experience, wisdom, or career-related burnout present in mid- and late-career clergy.

Stigma

Stigma is an important though understudied factor negatively impacting clergy seeking of professional psychological help. The stigma surrounding mental health and related symptoms includes concerns about public perception, resulting status loss, and marginalization due to

mental health service usage. In a survey of the health issues and service utilization of clergy members, Trihub et al. (2010) found that clergy named concerns about confidentiality as a prominent obstacle to their receiving needed support; clergy may be concerned with their ability to receive services without others knowing about it and thus are deterred from seeking support at all. This relationship between stigma and help-seeking has been broadly studied in the general population. In particular, the stigma surrounding mental illness has been consistently documented as having an impact on attitudes, beliefs, and treatment seeking for those with mental illness and psychiatric symptoms (Hogan, 2003; Angermeyer, Matschinger, & Corrigan, 2004; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Though quantitative research on mental health stigma in the clergy population is limited, existing research suggests that role identity, external expectations, and internalized stigma combine to deter clergy from help-seeking. To provide foundational understanding of the role of stigma in help-seeking, the stigma of mental illness will be defined, followed by a discussion of research on the relationship of mental health stigma to the stigma of help-seeking and help-seeking attitudes and intentions. Lastly, qualitative research on the stigma of help-seeking within the clergy population will be reviewed.

Stigma of mental illness. In early writing on stigma, Goffman (1963) defined it as the experience of being tainted or discounted due to some external attribute or condition. Stigma imputes a sense of imperfection on one's identity, rendering them less human or deficient in the eyes of others. Stigma manifests in attitudes and behaviors of those holding stigmatizing beliefs and consists of three components: stereotypes, collectively agreed-upon notions about a group of people; prejudice, beliefs that personally endorse and align with stereotypes and evaluate a group or persons as good or bad; and, discrimination, behaviors that are enacted in concert with

prejudicial beliefs (Corrigan & Kleinlein, 2005 in Corrigan & Watson, 2007; Corrigan & Watson, 2002; Corrigan & Rao, 2012). The stigma of mental illness impacts one's sense of self, causing individuals to internalize messages of being less valued because of a particular symptom or condition (Corrigan, 2004). Among many detrimental effects, the stigma of mental illness has been linked to lower self-esteem (Link et al., 2001), lower life satisfaction (Rosenfield, 1997), and a 15-20 year reduction in life expectancy (Piatt, Munetz, & Ritter 2010).

Although mental health treatment seeking has become more acceptable and some report a general decline in mental health stigma (Mojtabai, 2008), others assert that mental health stigma in the United States has not dissipated (Pescosolido, 2013). Stigmatizing attitudes about mental illness between 1996 and 2006 reflect this, with nearly one in three adults in the U.S. attributing schizophrenia or depression to bad character and a majority of individuals expressing an unwillingness to work closely with or socialize with a person with mental illness (Collins, Wong, Cerully, Schultz, & Eberhart, 2013). The stigmatization of mental health symptoms results in negative attributions toward those who express these symptoms. A systematic review of the research between 1987 and 2006 on the public stigma of mental health in the United States suggests that the public generally holds beliefs of incompetency, punishment, shame, criminality, and blame for those with mental illness (Parcasepe & Cabassa, 2013). As negative attributions increase, so does social distancing; social rejection increases for those with mental health conditions when individuals attribute the observed symptoms to personal responsibility, ascribe them as dangerous, and deem them to be rare (Feldman & Crandall, 2007).

Understanding stigma. Various explanations exist to describe how stigma works and explore its complexity. Stigma has been explained as a social phenomenon, one that cannot be separated from the culture in which it exists (Pescosolido, 2013). Factors such as gender,

ethnicity, and education levels have been associated with varying degrees of mental health stigma (Corrigan & Watson, 2007). For example, stigma surrounding the help-seeking for mental illness is less present in older individuals and women than in younger adults and men (Mackenzie, Knox, Gekoski, & Macaulay, 2004), and religious individuals have been found to have higher personal stigma about mental illness (Eisenberg, Downs, Golberstein, & Zivin, 2009). Using a social cognitive paradigm to understand mental health stigma, Corrigan (2000) proposed that stigma involves an internal process whereby signals in a person or environment (discriminative stimuli) prompt stereotypes (cognitive mediators) that impact discrimination (behaviors). Thus, one's mediating attitudes and cognitions about the causes of mental illness inform their behaviors in response to it. In yet another model, Corrigan and Rao (2012) suggested a staged process whereby stigma is internalized through a series of progressive phases. Individuals first become aware of public stigma toward a condition or symptom (Awareness). They then agree with the stereotypes of the condition (Agreement) and apply these stereotypes as true for themselves (Application). Finally, they experience resulting decreases in self-esteem and self-efficacy due to this self-application (Harm).

In important work that has shaped stigma research in the last two decades, Corrigan and Watson (2002) delineated two types of stigma associated with mental illness and the use of psychological services: public stigma and self-stigma. Public stigma refers to the general perception that certain traits or characteristics associated with mental illness are unacceptable and undesirable. Alternatively, self-stigma (also called internalized stigma) is marked by an internalized, reduced self-worth or self-esteem associated with the perception of one's being socially unacceptable because of those symptoms (Vogel, Wester, & Larson, 2007). Self-stigma is said to be the internalized negative perception of one's self in regard to mental health

characteristics or mental health help-seeking and is of particular interest in this proposed study.

Self-stigma of mental illness influences the impact of public stigma on attitudes and beliefs about mental illness and further influences help-seeking behaviors (Barney et al., 2006). Vogel, Wade, and Hackler (2007) found that self-stigma of mental illness fully mediated the relationship between public stigma of mental illness and willingness to seek counseling. Perceptions of public stigma related to mental illness significantly predicted self-stigma related to mental illness, which in turn significantly predicted attitudes and willingness to seek professional counseling services in relation to mental illness. Thus, one's perception of public opinion surrounding mental illness is not as direct an influence on their help-seeking attitudes as is their tendency to internalize this stigma. This relationship was further highlighted in a study of the longitudinal impact of public stigma of mental illness on self-stigma of mental illness. Here Vogel et al. (2013) confirmed that public stigma predicts self-stigma over time and that self-stigma is the more proximal variable when predicting help-seeking attitudes and intentions. Additionally, the self-stigma of mental illness has been found to mediate the relationship between the public stigma of mental illness and self-esteem (Brown et al., 2010).

Stigma and help-seeking. The stigma of mental health has serious implications for the help-seeking of those who struggle with symptoms and thus poses a significant public health concern (Corrigan, 2004; Vogel et al., 2013; Collins et al., 2013). Stigma inhibits the seeking of psychological services (Corrigan, 2004; Zartaloudi & Madianos, 2010) and is related to a reduction in intentions to seek counseling (Vogel et al., 2007). In fact, in a recent study of mental health care usage, only 41 percent of Americans who were affected by a mental health condition sought treatment for that condition in the preceding year (SAMHSA, 2015). Those who hold self-stigmatizing beliefs about mental illness avoid seeking services (Link et al., 2001) and those

who associate greater self-stigma with seeking help are less likely to return for services (Wade, Post, Cornish, Vogel, & Tucker, 2011). Conversely, the holding of positive attitudes about treatment is associated with significantly less stigma (Mann & Heimlein, 2004). Researchers have found that the greater the self-stigma the less likely individuals are to endorse intentions to seek help (Blais & Renshaw, 2013). Additionally, research demonstrates it is not simply having a disorder or symptoms that is stigmatized, but the seeking of help for that disorder (Vogel et al., 2007).

In the first systematic review of the relationship between mental health-related stigma and help-seeking, Clement et al. (2015) found that stigma and help-seeking had a significant negative correlation, that stigma is the fourth highest barrier to help-seeking, and that stigma has a moderate negative effect on help-seeking in comparison to other barriers. For 20-23% of participants across forty-four studies, stigma was a deterrent to seeking help because of associated shame, negative social judgment, and employment-related discrimination. Furthermore, stigma had a disproportionate effect on certain non-clergy populations, including ethnic minorities, males, young people, and those in the military and health occupations. Beyond just understanding stigma's negative impact, the exploration of links between stigma and help-seeking has been positioned as a social justice endeavor, presenting researchers and practitioners with opportunities to maximize support for those who need it most (Corrigan, 2004).

Researchers have attempted to parse out the differences between the public stigma of seeking psychological help and the self-stigma of seeking psychological help (Vogel et al., 2013). Greater public stigma of psychological help-seeking has been linked to greater internalized stigma of seeking psychological help (Vogel et al., 2007; Lannin et al., 2015). Similar to the stigma of mental illness, the self-stigma of seeking psychological help has been

found to mediate the effects of the public stigma of seeking psychological help on help-seeking attitudes and intentions (Ludwikowski et al., 2009; Lannin et al., 2015). Since attitudes toward help-seeking are strong predictors of actual help-seeking behaviors (Vogel et al., 2005), opportunities exist to increase help-seeking behaviors by targeting interventions on the self-stigma of seeking psychological help and the factors that influence its development.

Research has focused largely on two types of stigma (stigma of mental illness and stigma of help-seeking) and has identified both public and internalized versions of both. The self-stigma of mental illness and the self-stigma of help-seeking have been distinguished as two distinct constructs that can uniquely predict emotions related to stigma (like blame and shame), as well as attitudes and intentions to seek help (Tucker, 2013). In fact, Tucker demonstrated that self-stigma of seeking help accounted for a larger variance in attitudes toward help-seeking scores than the self-stigma of mental illness did, indicating it is the self-stigma of seeking help and not necessarily the internalized stigma about mental illness that most influences help-seeking. In an additional attempt to clarify the relationships between these stigmas, Lannin et al. (2015) studied the pathways by which mental health stigma (public and self) and help-seeking stigma (public and self) relate to self-esteem and help seeking intentions. They found that while the self-stigma of mental illness and the self-stigma of seeking psychological help are both associated with decreased self-esteem, only the self-stigma of seeking psychological help predicted counseling intentions. This again suggests that those who internalize stereotypes of mental illness may still have an openness to counseling. However internalized stereotypes about seeking psychological help may be particularly harmful to both self-esteem and help-seeking intentions. Lannin and colleagues described this as a double bind, wherein individuals who internalize stigma about help-seeking feel demoralized about the need for psychological help while also failing to get the

help they need. This research stresses the particular importance of assessing which stigma may be at work in individuals in order to guide counseling approaches. It also echoes research that points to the training of mental health clinicians and the use of the therapy room as the optimal places to address internalized stigma (Feldman & Crandall, 2007). Lastly, in efforts to understand self-stigma, researchers have encouraged exploration of the moderating relationships between self-stigma and other variables, such as type of disorder and severity of symptoms (Vogel et al., 2006).

Stigma and Help-seeking Among Clergy

Although existing qualitative research examining clergy help-seeking alludes to stigma as a deterrent for seeking of psychological services, this phenomenon has yet to be studied quantitatively for this population. Besterman-Dahan, Lind, and Crocker (2013) interviewed military chaplains who expressed fear of public perception and increased scrutiny should they seek support for mental health problems. In another study, Isacco and colleagues (2014) studied Catholic priests and found that those who had not sought mental health treatment cited social stigma and the public nature of their ministerial role as reasons. In yet another study, Pietkiewicz and Bachryj (2016) found that although the majority of their clergy participants had utilized professional psychological services, these clergy still maintained a view of help-seeking as stigmatizing and communicated general resistance toward it.

If clergy help-seeking mirrors that of other religious individuals, their degree of conservatism or liberalism could have an impact on the stigma they hold about seeking psychological services. One study found that congregants espousing liberal beliefs were more trusting in seeking psychological support from non-clergy outsiders while those with conservative religious beliefs have stronger biases against seeking outside support (Zellmer &

Anderson-Meger, 2011). For conservative Christians in particular, the stigma associated with mental illness could influence their engagement in more blaming attributions related to mental health as well as a belief that individuals are responsible for the onset of their symptoms (Dain, 1992). Such attributions increase shame, reduce a likelihood of reaching out for help, and make the stigma associated with mental illness more salient for these religious individuals.

One indicator of stigma among clergy is the fact that they cite fears of negative evaluation if their help-seeking was discovered. In a study by Holaday et al. (2001) of clergy who experience secondary traumatization, few clergy reported seeking counseling. Young clergy in particular communicated a hesitancy about revealing stress and vulnerability for fear of appearing incompetent: "Participants might have been concerned that scores reflecting negative feelings would be viewed as an indication that their role in the congregation was impaired or diminished by comparison with their colleagues" (p. 69).

Evidence that mental health stigma may influence clergy determinations about help-seeking also exists in research from the Duke University Clergy Health Initiative (Proeschold-Bell et al., 2011). Among their studies on clergy health and wellness, qualitative research with 59 Methodist pastors and 29 regional superintendents examined moderators of clergy health within intrapersonal, interpersonal, congregational, institutional, and community realms. Clergy in this study stated they were more likely to engage in health care practices of all kinds when congregants supported them, a nod to the importance clergy might place on congregational opinions about their actions. Researchers stopped short of naming mental health stigma within the clergy population; however, they suggested policy changes to improve the confidentiality around health care service utilization so that clergy would not fear the negative evaluation of

denominational leaders and congregants, nor the resulting financial impact that health care use might cause.

In another study on the personal coping of evangelical clergy in distress, Meek et al. (2003) uncovered similar mental health needs and alluded to stigma among this population. The authors acknowledged that the occupational stressors of ministry may necessitate eventual use of counseling services: "Because of the great demands pastors face, there will undoubtedly always be a need for counseling " (p. 8). Furthermore, their participants echoed themes of stigma as an obstacle to pursuing counseling:

> Not surprisingly, there is great fear of negative reprisal. Will it be perceived as weakness or professional incompetence? Will it be a sign to others that God is not enough? Pastors are especially concerned about who will have access to the information making confidentiality an issue of paramount importance. (p. 9)

Clergy and Stigma – A Role Identity Theory Lens

The research reviewed thus far has contextualized clergy and mental health stigma across the following domains: the public nature of the clergy occupation, the high levels of isolation and burnout that typify clergy work, the high expectations and demands that congregants ascribe to clergy, the distress and psychological symptoms that clergy experience, and clergy concerns about confidentiality and negative reprisal that accompany help-seeking when in distress. Additionally, an introduction to mental health stigma and help-seeking stigma has provided a foundation for understanding stigma as a deterrent to help-seeking for those who experience psychological symptoms. To provide further context for the proposed study, a conceptualization of clergy and mental health stigma is aided by considering the intersections of role identity and distress.

The impact of stigma on help-seeking is inevitably influenced by social position and occupational prestige. Research on other public figures and helping professionals is informative here. For example, medical doctors (Adams, Lee, Pritchard, & White, 2010) and school leaders (Nir, 2009) exhibit a reluctance to seek mental health support due to a fear of the loss of status. The combination of role demands and public expectations in public leaders and caregivers combine powerfully to dissuade them from exhibiting traits that could be deemed by others as deficient.

Role identity theory (McCall & Simmons, 1978) provides a useful lens for interpreting the way role demands impact caregivers (Siebert & Siebert, 2005) and clergy specifically (Pooler, 2011), including their identification of personal struggles and their requests for help. Role Identity Theory has roots in symbolic interactionism and concerns itself with how individuals make meaning out of their identities and the roles they play. The theory posits that role identities are idiosyncratic and idealized conceptions of the self, behavior is motivated by the idealized roles that one plays, and more salient roles have a stronger influence on one's behavior (McCall & Simmons, 1978). Roles are reinforced by the expectations of others as well as the expectations of the self, and one's role identities are both influencers of daily actions and form the criteria by which an individual will appraise their performance in any given role. When one's idealized role identity proves to be inconsistent with reality, he/she will work to maintain these perspectives of him/herself and legitimate that role identity through role-performances, or behaviors consistent with the idealized view of him/herself. Role-support comes in the form of actions and reactions of others surrounding that person and serves to confirm his/her idealized imaginations of the self.

Role identity theory also provides a helpful explanation for impairment in those in the helping professions because it emphasizes the intersection of personal, professional, and self-expectations (Siebert & Siebert, 2005). Role identity is not just the conceptualized role that one creates for one's self within a particular social position. It is the "imaginative view of himself *as he likes to think of himself being and acting as an occupant of that position*" (McCall, 1977 as cited in McCall & Simmons, 1978, p. 65). The inability of one to legitimate his/her idealized role identity can result in tension between the imagined self and reality, resulting in embarrassment or social scrutiny. In the case of caregivers, it can be difficult to acknowledge personal problems or ask for help when individuals find themselves having the same problems as those for whom they give care. In these instances, their "idealized image of themselves would be at odds with the reality of their personal problems" (Siebert & Siebert, 2005, p. 205). For helping professionals, role identity can be particularly salient as their work in serving others in need (the helped) may serve to reinforce their view of themselves as the one who is *not* in need (the helper), thus magnifying tension when reality contradicts their role identity. For example, Siebert and Siebert (2005) found that caregiver role identity in social workers was positively correlated with professional impairment, burnout, depression, and was correlated negatively with seeking help for personal problems. The stronger the caregiver role identity, the more social workers experienced psychological and occupational distress and the less they sought help for their personal problems.

Pooler (2011) asserts that role identity theory is useful in understanding why clergy have difficulty identifying personal problems and asking for help. As congregants place emphasis and importance on clergy roles, clergy experience themselves being put on a pedestal. They then respond to these expectations which guide their behavior. A merging of role identity and self-

concept occurs and clergy continually choose actions that support their role and that are consistent with the identity. These idealized identities are frequently unattainable in real life and become particularly burdensome when realities inconsistent with an esteemed role, such as distress or psychological illness, beset clergy.

Role identity theory encompasses the self-categorization and social comparison (Pooler, 2011) that inform mental health stigma. As noted earlier, stigma involves the act of being discounted or discredited due to some mark or trait (Goffman, 1963). In social interaction, that trait is understood in the context of social norms which dictate the desirability of that trait. When clergy exhibit positive qualities, their social comparison and self-categorization result in secure ingroup membership. Pooler (2011) suggested that when clergy experience symptoms deemed negative (e.g. neediness, substance abuse, depression, lust) – those they more typically ascribe to the congregants they seek to help – they may deny these qualities or bolster actions that counter these qualities (e.g. more attention to others' needs), thus exacerbating their vulnerabilities. Additionally, they may experience increased aversion to seeking help. As Pooler stated, "When one's primary role identity is around giving care, the identity itself is the barrier that interferes with asking for help" (p. 708). In this way, salient role identity for clergy and other caregivers could heighten the experience of diminished self-esteem and outgroup membership when they inhabit roles, such as *depressed person*, that they do not see emulated in the members of the larger clergy community. Furthermore, research shows that the stigma of help-seeking is a threat to self-concept above and beyond the stigma of mental illness (Tucker et al., 2013), thus making it increasingly hard for those who cling to their healthy identity to ask for needed mental health support. Reducing the stigma surrounding clergy help-seeking could both validate clergy role

identity and normalize the need for non-punitive and supportive responses to clergy mental health concerns (Pooler, 2011).

Stigma and Self-Compassion

Vogel et al. (2013) recommended a focus on internal factors and other mediating variables as a direct way to influence the magnitude of self-stigma's influence on help-seeking. One such internal factor gaining attention in psychological literature is self-compassion. Self-compassion is the ability to take a warm and accepting stance toward oneself, particularly the parts that are disliked (Neff, Rude, & Kirkpatrick, 2007). The practice of self-compassion involves three distinct components: kindness to the self when there is perceived inadequacy or suffering; recognition that experiences of pain or inadequacy are an unavoidable part of being human, and thus experienced by all human beings; and, the ability to hold difficult thoughts and feelings with balanced awareness, rather than avoidance, exaggeration, or self-pity.

Research reveals the positive implications of self-compassion in applied psychology. Self-compassion has been identified as a buffer against acute stressors (Neff, Kirkpatrick, & Rude, 2007) as well as a predictor of mental health and psychological strengths (Neff, 2003). Self-compassion protects against low self-esteem in adolescents (Marshall et al., 2015), increases protective factors like optimism and happiness (Neff et al., 2007), improves one's ability to relate to oneself (Neff, 2009), increases one's ability to transform human suffering (Young-Eisendrath, 2008), improves self-regulation and health (Terry & Leary, 2011), and correlates highly with health promoting behaviors (Sirois et al., 2014). In a 2012 meta-analysis of self-compassion and psychopathology, MacBeth and Gumley (2012) found that increased self-compassion correlated strongly with low levels of mental health symptoms.

Clergy research points to the potentially powerful role of self-compassion with this population, given their unique occupational demands and stressors. Pooler (2011) called attention to opportunities for emphasizing the humanity and humanness of clergy amidst salient and idealized role identities that involve high performance and high expectations. Proeschold-Bell et al. (2013) suggested the importance of normalizing clergy's predominant guilt when they are unable to meet exceedingly high congregational demands. Doolittle (2007) advocated for fostering adaptive and coping strategies among clergy to better handle the high stress and burnout in this population. Finally, Proeschold-Bell et al. (2015) asserted that the pervasive isolation among clergy, and its impact on mental health, calls for reminders to clergy that they are not alone. Self-compassion urges a gentleness with oneself in the face of high expectations (Neff, 2003), for example when clergy's self-concept does not match their role identity or the expectations of their congregation. Self-compassion also promotes a practice of situating one's suffering and difficult emotions in the context of all of humanity, a way to potentially assuage clergy feelings of isolation and guilt. Lastly, self-compassion supports the seeking of balance and the mindful holding of difficult emotions, a skill particularly useful for clergy, whose occupation comes with high levels of distress.

The relationship between self-compassion and stigma has gained only minimal attention in literature. For example, in a study of obese individuals in Germany (Hilbert et al., 2015), researchers found that self-stigma predicted greater depression, somatic complaints, lower quality of life and lower health status, but that self-compassion partially mediated the relationship between self-stigma and these variables, lowering them by one-third, and acting as a buffer for both health and mental health symptoms. In an additional study of help-seeking and stigma, Heath and colleagues (2016) found that among those reporting higher public stigma

related to psychological help-seeking, individuals with higher self-compassion reported lower anticipated self-stigma than did those reporting lower self-compassion. Self-compassion may lend psychological resilience when stigma occurs and may attenuate the relationship between perceived public stigma and anticipated self-stigma.

As divinely called servants, clergy frequently extend compassion for others. Clergy work is typified as self-denying, servant oriented, and focused on the poor, hurting, and marginalized. However, the ability to extend compassion to others is distinctly different than the ability to extend compassion to oneself (Neff, 2003). In fact, excessive levels of clergy distress and burnout amidst high congregational expectations might suggest clergy have difficulty applying the gentle acceptance that characterizes self-compassion to themselves. In a study of Methodist clergy, self-compassion had a significantly negative correlation with burnout and a significant correlation with satisfaction in the ministry (Barnard & Curry, 2012). With respect to the stigma of mental health and help-seeking, self-compassion in clergy could prove vital in their well-being, their normalization of distress, and their ability to resist the impact of stigma in favor of pursuing services needed to optimize their wellness.

CHAPTER 3

Method

This study uses a quantitative method and a descriptive correlational design with data acquired from clergy across the United States. It explores the relationships between clergy distress, caregiver role-identity, self-compassion, self-stigma of help seeking, and attitudes toward professional psychological help-seeking using regression analyses. The data was gathered through online survey responses and instruments including the Patient Health Questionnaire-9 (PHQ-9), the Caregiver Role Identity Scale (CRIS), the Self-Compassion Scale (SCS), the Self-Stigma of Seeking Help Scale (SSOSH), and the Attitudes Toward Professional Psychological Help-Seeking Scale (ATPPHS).

Participants

Based on an *a priori* power analysis for a small to moderate effect size when correlating the independent variables, it was determined that approximately 127 clergy members were needed to participate in order to achieve a power of .80. Data was collected from 192 clergy members. Tables 1 and 2 summarize the sample demographics. The average age of respondents was 54 years old. Males represented 62% (n = 119) of respondents and females represented 37% (n = 71) of respondents. One respondent identified as Gender Fluid and one respondent declined to provide gender information. The majority of respondents identified as Caucasian/White American (91.1%, n = 175) and 78.6% (n = 151) of respondents were married. With regard to education status, 67.2% (n = 129) had received master's degrees and 21.9% (n = 42) had received doctoral degrees. Regarding work status, 71.4% (n = 137) of respondents work as full-time clergy while 28.6% (n = 55) work as part-time clergy. Nearly half of respondents (47.4%, n = 91) reported serving in the ministry for over 21 years.

Table 1
Demographics of Sample

Gender		N	%
	Male	119	62
	Female	71	37
	Gender fluid	1	.5
	No response	1	.5
Ethnicity/Race			
	Asian American	2	1
	Black / African American	4	2.1
	Caucasian / White American	175	91.1
	Native American	3	1.6
	Multi-racial	3	1.6
	Other	5	2.6
Education			
	High School Diploma	5	2.6
	Associate Degree	1	.5
	Bachelor's Degree	15	7.8
	Master's Degree	129	67.2
	Doctoral Degree	42	21.9
Years of Service			
	Less than 1 year	5	2.6
	1-2 Years	11	5.7
	3-5 Years	11	5.7
	6-10 Years	26	13.5

11-15 Years	30	15.6
16-20 Years	18	9.4
Over 21 Years	91	47.4

Table 2
Age of Sample

	N	*Minimum*	*Maximum*	*Mean*	*Std. Deviation*
Age	187	23	83	54.67	13.107

Measures

Demographics. Demographic questions regarding gender, marital status, race/ethnicity, rural/urban church designation, U.S. region where practicing ministry, age, years in ministry, education, whether or not clergy have a history of accessing psychological services, and denominational affiliation were included as part of the demographic questionnaire (Appendix A).

Distress. Clergy distress was assessed using the Patient Health Questionnaire-9 (PHQ-9; Appendix B). The PHQ-9 is a nine-item scale used to measure depression symptoms over the past two weeks (Kroenke, Spitzer & Williams, 2001; Spitzer et al., 1999). Respondents provide answers on a Likert scale where 0 = *Not at all* and 3 = *Nearly every day*. An example item is "Over the last two weeks, how often have you been bothered by feeling down, depressed, or hopeless." Depression scores range from 0 to 27, with higher scores indicating more severe depression symptoms. Researcher have designated a cut-off of 10 or higher as indicative of depression (Kroenke & Spitzer, 2002).

The PHQ-9 demonstrates good internal reliability (α = .89). It has been validated as a useful tool for diagnosis by mental health professionals (Diez-Quevedo, Rangil, Sanchez-Planell, Kroenke, & Spitzer, 2001), as a helpful tool to identify depression in the general population

(Martin, Rief, Klaiberg & Braehler, 2006), and it has demonstrated convergent validity with other tools to assess depression, such as the Mental Health Inventory (MHI-5) (Kroenke et al., 2001). The PHQ-9 also has been used in a current line of research on clergy well-being, clergy burnout, and clergy mental health emerging from the Duke University Clergy Health Initiative where high PHQ-9 depression scores of Methodist clergy have been significantly associated with high extrinsic demands related to job stress, social isolation, guilt, and doubting one's call to ministry (Proeschold-Bell et al., 2013).

Self-stigma. Clergy self-stigma of help-seeking was measured using the Self-Stigma of Seeking Psychological Help (SSOSH) scale (Vogel, Wade, & Haake, 2006; Appendix C) which measures the extent to which an individual would feel a loss of self-esteem, increase in shame, and overall reduction in self-worth in response to mental health help-seeking. The scale contains 10 items requiring responses on a 5 point Likert scale from 1 = *Strongly Disagree* to 5 = *Strongly Agree*. A sample item from this scale is "I would feel inadequate if I went to a therapist for psychological help." Scores range from 5 to 50. Higher scores indicate higher degrees of personal stigma toward mental health help-seeking, with a score of 30 indicating the cutoff between low and high self-stigma.

The SSOSH scale has high internal consistency reliability, with Vogel, Wade, and Haake (2006) reporting on three studies with alphas of .91, .89, and .88 respectively. The SSOSH demonstrated good test-retest reliability over a 2-month period (r = .72). The measure had significant convergent validity with attitudes toward seeking psychological help (a significant negative correlation) and social stigma for seeking psychological help (a significant positive correlation). The SSOSH has been found in undergraduate students to correlate negatively with intentions to seek counseling (Wade et al., 2011) and to be positively associated with endorsed

(or public) stigma and negatively associated with attitudes to seek counseling (Bathje & Pryor, 2011). Additionally, the SSOSH had a small-to-moderate significant correlation ($r = .37$, $p < .001$) with the Help-Seeker Stereotype Scale (HSSS), a scale intended to measure endorsements of negative stereotypes about individuals seeking help from psychologists (Hammer & Vogel, 2016). Lastly, using the SSOSH, Vogel et al. (2007) found that self-stigma correlated negatively with three observed indicators (parcels) for the latent variables of the shortened form of Fischer and Turner's (1970; Fischer & Farina, 1995) Attitudes Toward Seeking Professional Psychological Help Scale ($r = -.43$ to $-.56.$, $p < .01$)

Role identity. Caregiver role identity was measured using the Caregiver Role Identity Scale (CRIS) (Siebert & Siebert, 2005; Appendix D). The CRIS was originally created for use with social workers to operationalize role identity theory's dual tenets of respondents' views of themselves as helpers and their perceptions of other's views of them as helpers (Siebert & Siebert, 2007). The scale consists of 10 items requiring responses on a Likert scale where 1 = *strongly disagree* and 5 = *strongly agree*. Summed scores range between 10 and 50, with higher scores indicating a stronger degree of caregiver role identity. The CRIS items fall along the two facets of role identity: how individuals view themselves and how individuals perceive that others view them. A coefficient alpha of .78 for the scale indicates good validity.

Though research using CRIS is limited, its initial validation revealed convergent validity with measures of burnout and impairment. In particular, the scale correlated positively with the Center for Epidemiological Studies–Depression (CES-D) measure ($r = .53$, $p < .00001$) and the Maslach Burnout Inventory ($r = .18$, $p < .00001$) (Siebert & Siebert, 2005). In a more recent study of social workers, the CRIS was positively correlated with psychological distress ($r = .16$, $p < .05$) and negatively correlated with self-esteem ($r = -.51$, $p < .01$) (Wu & Pooler, 2014).

CRIS creators have developed a similar scale, the Emergency Medical Services Role identity Scale (EMS-RIS), to capture the role identity of emergency responders (Donnelly, Siebert, & Siebert, 2015). In their validation of the EMS-RIS they found the caregiving subscale of their new scale to have convergent validity with the original CRIS ($r = .53$, $p < .01$).

Self-compassion. The Self-Compassion Scale (SCS; Neff, 2003) was used to assess clergy self-compassion (Appendix E). This is a self-report scale containing 26-items, with a 5-item Self-Kindness subscale (e.g., "I try to be loving toward myself when I feel emotional pain"), a 5-item Self-Judgment subscale (e.g., "I'm intolerant and impatient towards those aspects of my personality I don't like"), a 4-item Common Humanity subscale (e.g., "When things are going badly for me, I see the difficulties as part of life that everyone goes through"), a 4-item Isolation subscale (e.g., "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world"), a 4-item Mindfulness subscale (e.g. "When something upsets me I try to keep my emotions in balance"), and a 4-item Over-Identification subscale (e.g., "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). Respondents rate their answers on a 5 point scale from 1 = *Almost Never* to 5 = *Almost Always*, with mean scores on each subscale averaged to create an overall self-compassion score. A higher score indicates higher self-compassion.

Validation of the SCS (Neff, 2003) revealed high inter-correlation between subscales. The single higher-order factor of self-compassion was found through confirmatory factor analysis to explain self-compassion as a second-order trait arising from a combination of each of the sub-traits. The SCS demonstrates good internal consistency reliability ($\alpha = .92$) and good test-retest reliability ($r = .93$) over a three-week interval.

The SCS has been found to correlate with several other measures. It has correlated

positively with positive affect (r = .34, p < .05) and negatively with negative affect (r = −.36, p < .05) as measured by the Positive and Negative Affect Scale and it has a strong negative correlation with neuroticism (r = −.65, p < .05) as measured by the Neuroticism-Extraverson-Openness (NEO) Five-Factor Inventory, Form S (Neff, Rude, & Kirkpatrick, 2007). The SCS is also highly correlated with measures of well-being over a one-month treatment interval, including a negative correlation with self-criticism as measured by the Self-Criticism subscale of the Depressive Experiences Questionnaire (r= −.61, p < .01), a positive correlation with connectedness as measured by the Social Connections Scale (r = .35, p < .05), a negative correlation with thought suppression as measured by the White Bear Suppression Inventory (r = −.55, p < .01), and a negative correlation with depression as measured by Beck Depression Inventory (r = −.31, p < . 05) (Neff, Kirkpatrick, & Rude, 2007). In a meta-analysis of self-compassion studies and health behaviors across community and student samples, Sirois et al. (2014) found that the SCS was positively associated with health promoting behaviors (r = .25, k = 1, p < .001) such as healthy eating, exercise, and sleep habits. In a meta-analysis of self-compassion and psychopathology, MacBeth and Gumley (2012) found that the SCS was correlated negatively with measures of depression, anxiety, and stress. Lastly, in a study of clergy, researchers found that self-compassion had a significant negative correlation with burnout (r = −.60, p < .001) (Barnard & Curry, 2012).

Help-seeking attitudes. Help-seeking attitudes were measured using the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Turner, 1970) (Appendix F). The scale contains 29 Likert items requiring respondents to rate answers from 0 = *Disagree* to 3 = *Agree*. Eleven of the items are positively stated and eighteen are negatively stated, requiring reverse scoring. Total scores on the scale range from 0 to 87, with higher total

scores indicating more positive attitudes toward seeking professional help. A sample item from this scale is "If I believed I was having a mental breakdown, my first inclination would be to get professional attention." To update and increase inclusiveness of the language, items referencing a *psychiatrist* were edited to include *psychologist* and *counselor*, items referencing *he*/*him/himself* were edited to include *she*/*her/herself*, and items referencing *psychotherapy* were edited to include *counseling*.

The scale demonstrates good internal reliability, with alphas of .86 and .83 on two administrations for scale validation with college samples (Fischer & Turner, 1970). The measure also demonstrated good test-retest reliability after two months (r = .84). The scale consists of four factors: recognition of personal need for professional psychological help (8 items), tolerance of the stigma associated with psychiatric help (5 items), interpersonal openness regarding one's problems (7 items), and confidence in the mental health professional (9 items). Since scale authors found the subscales to lack internal consistency, they recommended using total scale scores alone for this measure. In initial validation, Fisher and Turner found that social desirability did not impact subjects' responses in either anonymous or identifiable conditions.

A shortened, 10-item version of the ATSPPH scale with similar psychometric properties (Fischer & Farina, 1995) has been more predominantly used in psychological literature. The shortened version was created to provide ease of administration and scoring and correlated with the full scale scores (r = .87). For purposes of this study, the longer ATSPPH scale was used to allow for sufficient variability in the outcome variable being measured. Nonetheless, examination of the shortened ATSPPHS lends credence to the validity of the attitude toward help-seeking construct and to its applicability in help-seeking and mental health stigma literature. For example, Vogel and colleagues (2005) found that the shortened ATSPPHS was positively

associated with intentions to seek counseling (r = .56) and correlated negatively with tendencies toward self-concealment (r = −19). Cepeda and Benito (1998) also found that attitudes, as measured with the shortened ATSPPH scale, significantly predicted college participants' perceived intentions to seek help. The shortened form of the ATSPPH has correlated negatively with responses on the Self-Stigma of Seeking Help Scale (r = −.25, p < .001) (Hammer & Vogel, 2007) and correlated positively with responses on the Intentions to Seek Counseling scale (r = .43, p < .001) in college samples (Tucker et al., 2013). Additionally, Vogel et al. (2007) found that latent variables of the shortened ATSPPH scale correlated negatively with the Self Stigma of Seeking Help scale (r = −. 43 to −.56., p < .01).

A single study validated the shortened form of the ATSPPH scale with a religious population (Royal & Thompson, 2012). In this study, 511 Protestant Christians were administered the scale and item analysis revealed it to be a valid measure of this religious population's attitudes toward seeking professional psychological help. In this case, researchers found that data were sufficiently unidimensional, person reliability estimates were between .77 and .81, and item reliability estimates were .98. Overall, their Protestant Christian sample found it difficult to seek out psychological services.

Procedure

Snowball sampling was used to recruit participants, and measures were distributed via email (Appendix G). The researcher contacted a personal network of clergy and a network of denominational leaders with access to clergy email listservs across the United States. Recipients were asked to share the survey with clergy in their vicinity and in their personal networks. The email contained a link to an online survey in Qualtrics software which was used to collect survey responses. Participants were informed via consent forms about the purpose of the research and

their ability to participate and/or withdraw at any time. Measures were administered in Qualtrics in the following order: Demographics Questionnaire, Patient Health Questionnaire-9, Self-Stigma of Seeking Help Scale, Caregiver Role Identity Scale, Self-Compassion Scale, and Attitudes Toward Professional Psychological Help-seeking.

CHAPTER 4

Results

This study was designed to examine the relationships between clergy distress, self-stigma of help-seeking, caregiver role identity, self-compassion, and attitudes toward professional psychological help seeking. This chapter describes procedures used to analyze the data, demographic information on the clergy sample, descriptive statistics, and the assumptions and results of the hierarchical regressions performed to address this study's research questions.

Preliminary Analyses

Two hundred and twenty-three clergy members accessed the survey and gave their informed consent to complete it. Of those clergy, 192 (83%) surveys were completed in their entirety. Thirty-one surveys (14%) contain a significant amount of missing data as a result of non-completion. To assess possible randomness of missing data responses, Little's MCAR (missing completely at random) test was conducted in SPSS (Keith, 2015). This resulted in a chi-square of 29.254 (df = 34; p = .699), which indicates that the data were missing completely at random. It can therefore be determined that the reason for the missing data was unrelated to the values of the variables assessed. To improve the accuracy of estimates of means, covariances, variances, and effects (Keith, 2015), the 31 cases with missing data were deleted prior to further analysis, resulting in 192 cases for this study.

Descriptive Analyses

Descriptive statistics were calculated for all the demographics and scaled variables. Tables 1 and 2 summarize the sample's demographics, including ethnicity, gender, education obtained, years of service in the ministry, and age. It is notable that nearly half of clergy respondents had served in the ministry for more than 21 years. The age of the sample spanned 23

to 83, with an average age of 54. A majority (91.1%) of respondents identified as Caucasian/White American, with other ethnicities being Other (2.6%), Black/African American (2.1%), Native American (1.6%), Multiracial (1.6%), and Asian American (1%). Of the respondents, 68% were male and 37% were female, with 1% providing no response or identifying as gender fluid. Married clergy represented 78.6% of the sample and 89% of the sample had a Masters or Doctorate degree.

Table 3 shows the frequencies of clergy's use of various resources for support. As expected, the majority of the participants relied heavily upon spouse, friends, clergy peers, and their spiritual resources. Of particular note is that 61.5% of respondents had utilized individual counseling and 24% had used psychiatric medications as a means of supporting their well-being.

Table 3
Clergy Use of Resources

Resource	Yes	%
Spouse	180	98.3
Friends	187	97.4
Clergy Peer Group	172	89.6
Spiritual Resources	187	97.4
Individual Therapy	118	61.5
Couples Therapy	41	21.4
Family Therapy	14	7.3
Psychiatric Meds.	46	24
Substance Use Counseling	9	4.7

Table 4 provides a summary table of the means and distribution of the scaled variables. Compared to samples used in norming these scales, none of the means appear extreme, although some differences are noted. As noted previously, a score of 10 or higher on the PHQ-9 was used

as a cut-off to indicate depression in the past two weeks (Kroenke & Spitzer, 2002). As shown in Table 5, the prevalence of depression for this sample as indicated by score of 10 or higher was 13% (n = 25). This was slightly higher than PHQ-9 scores found in other clergy research where depression prevalence was 11.1% (Proeschold-Bell et al., 2013). The mean of self-stigma for this clergy sample (*M* = 18.73, *SD* = 5.75) falls slightly below the self-stigma mean reported in the validation study for the SSOSH scale (*M* = 27.1, *SD* = 7.7), which was normed on college students. The clergy mean for the CRIS (*M* = 36.53, *SD* = 6.57) is higher than the mean for the sample of 744 social workers (*M* = 28.86, *SD* = 4.92) on which that measure was normed (Siebert & Siebert, 2005). The mean for self-compassion in this sample (*M* = 3.47, *SD* = 0.67) is higher than the range of means (*M* = 2.84 – 3.11) detailed by Sirois et al. (2014) in their meta-analysis of fifteen studies, which used the SCS with high school, college, and graduate students. Additionally, the mean for ATPPHS in this sample (*M* = 62.81, *SD* = 6.23) was in the range of means found during the validation of this measure on college males (*M* = 56.1, *SD* = 11.8) and college females (*M* = 63.2, *SD* = 11.4, Fischer and Turner, 1970).

Table 4
Descriptives for Major Study Variables

	Min.	*Max.*	*Mean*	*Std. Deviation*	*Skewness*		*Kurtosis*	
					Statistic	*SE*	*Statistic*	*SE*
PHQ 9 TOTAL	0	24	4.48	4.534	1.488	.175	2.445	.349
SSOSH TOTAL	10	38	18.73	5.745	.660	.175	-.179	.349
CRIS TOTAL	10	50	36.53	6.574	-.551	.175	.985	.349
SCS TOTAL	1.43	5.00	3.4681	.66601	-.324	.175	-.101	.349
ATSPPHS Total	8	83	62.81	16.233	-1.510	.175	2.160	.349

Table 5
PHQ-9 Total Scores

	Frequency	*Percent*
Score of 0-4 (None)	118	61.5
Score of 5-9 (Mild depression)	49	25.5
Score 10-14 (Moderate depression)	16	8.3
Score 15-19 (Moderately severe depression)	7	3.6
Score 20-27 (Severe depression)	2	1.0
Total	192	100.0

Denominational affiliation was collected as a categorical variable with 16 original categories: 15 denominations which were based on the Pew Forum's *Fifteen Largest Protestant Denominations* (Pew Research Center, 2015) and an Other category for respondents to write in their denomination. Several respondents identified themselves in the Other category as Unitarian Universalist, Pagan, or opted not to provide a descriptor. Two respondents identified themselves as Catholic, so a Catholic category was added. The denominations that had zero records (Assemblies of God, Lutheran Church Missouri Synod, Presbyterian Church in America, Church of God, American Methodist Episcopal, and Pentecostal) were removed as categories for analysis. Also for analysis, the remaining denominations were further collapsed into 10 categories (with 1 Other category) that combined similar denominations together (e.g. Southern Baptist and Cooperative Baptist were combined into Baptist). This combining was based on the knowledge that, despite nuanced differences in doctrine within denominational sects or subcategories, larger denominations (e.g. Methodist, Lutheran, Baptist) share historical ties and engage in similar beliefs and practices (Rhodes, 2005). Frequencies for denominational affiliation are provided in Table 6.

Table 6
Denominational Affiliation

	Frequency	%
1 Baptist	64	33.3
2 Methodist	16	8.3
3 Church of Christ Christian	6	3.1
4 Lutheran	6	3.1
5 Presbyterian	16	8.3
6 Congregational	36	18.8
7 Evangelical Free Church	1	.5
8 Non-denominational	5	2.6
9 Catholic	2	1.0
10 Episcopal	34	17.7
11 Other	6	3.1

Correlational Analyses

Correlations among study variables were calculated and are provided in Table 7. In this sample, gender was correlated significantly with age ($r = -.158$, $p < .05$), indicating more females on the lower end of the age distribution, and with years of service ($r = -.260$, $p < .01$), indicating females in this sample have fewer years of service. However, gender was not significantly correlated with any of the other predictor or criterion variables.

It was hypothesized that distress would be positively correlated with self-stigma in this sample. Counter to the hypothesis, the relationship between distress and self-stigma was non-significant. It was also hypothesized that distress would be negatively correlated with help-seeking attitudes. For this sample, the correlation between distress and help-seeking attitudes was non-significant.

Table 7
Correlations

		1	2	3	4	5	6	7	8
1.	Gender (M/F)								
2.	Age	−.158*							
3.	Years served	−.260**	.461**						
4.	Education	−.034	.200**	.270**					
5.	PHQ 9	.130	−.283**	−.249**	−.082				
6.	SOSSH	−.113	.121	.095	−.021	−.035			
7.	CRIS	.036	−.251**	.006	.070	.309**	−.160*		
8.	SCS	−.035	.295**	.103	.134	−.487**	−.175*	−.219**	
9.	ATPPHS	.082	-.022	.036	.125	−.041	−.331**	−.010	.218**

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

This study also hypothesized that caregiver role identity would be positively correlated with self-stigma. In this sample, this hypothesis was not supported. Instead, there was a negative correlation of caregiver role-identity with self-stigma and this was statistically significant ($r = -.160$, $p < .05$), with higher levels of caregiver role-identity associated with lower levels of self-stigma.

It was hypothesized that self-compassion would be negatively correlated with self-stigma. This hypothesis was supported; there was a negative correlation of self-compassion with self-stigma and this was statistically significant ($r = -.175$, $p < .05$), with higher levels of self-compassion associated with lower levels of self-stigma.

Additionally, it was hypothesized that self-stigma would be negatively correlated with help-seeking attitudes. This hypothesis was supported; self-stigma was significantly correlated with help-seeking attitudes ($r = -.331$, $p < .01$), and this was a moderate effect size (Cohen, 1988). Thus, higher levels of self-stigma were associated with less favorable attitudes toward help-seeking in this sample.

Several additional correlations were found for caregiver role-identity and self-compassion. Caregiver role identity significantly correlated with distress ($r = .309$, $p < .01$) with a moderate effect size (Cohen, 1988), suggesting that a more salient caregiver role-identity is associated with higher levels of distress in these clergy. With regard to caregiver role identity and help-seeking attitudes, the correlation was not significant. Self-compassion correlated with distress ($r = -.487$, $p < .01$), with a medium effect size, revealing that those higher in distress had lower self-compassion. Self-compassion also correlated with caregiver role identity ($r = -.219$, $p < .01$), with a small effect size, which shows that those with more salient caregiver role identities had lower self-compassion. Lastly, self-compassion was correlated with attitudes toward help-seeking ($r = .218$, $p < .01$) with a small effect size; those with more self-compassion held more favorable attitudes toward help-seeking.

Additional correlations of interest occurred with years served in the ministry, age, and conservative/liberal orientation. A significant correlation between years served in the ministry and distress ($r = -.249$, $p < .01$) showed that the longer clergy had served in the ministry, the less distressed they were. Age also significantly correlated with distress ($r = -.283$, $p < .01$) revealing that older clergy were less distressed. Older age was also associated with a less salient caregiver role identity ($r = -.251$, $p < .01$) and with more self-compassion ($r = .295$, $p < .01$); the older the clergy were in this sample, the less strongly they identified with a caregiver role identity and the more they endorsed practices of self-compassion. Lastly, clergy self-rated conservativism/liberalism correlated with self-stigma ($r = -.178$, $p < .05$) and with help-seeking attitudes ($r = .207$, $p < .01$), revealing that those with higher self-identification with liberal religious beliefs endorsed less self-stigma and more favorable attitudes toward help-seeking.

Analysis of Denominational Differences

Denomination means and standard deviations for scaled variables and for conservative/liberal self-ratings were calculated and are provided in Table 8 and Table 9.

Table 8
Denomination Means and Standard Deviations for Scales

		PHQ-9		CRIS		SSOSH		SCS		ATPPHS	
	N	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
1 Baptist	64	4.84	5.17	37.52	6.92	18.73	5.66	3.42	.7019	62.13	17.06
2 Methodist	16	3.00	2.66	35.94	7.61	19.63	6.84	3.60	.6639	68.63	9.16
3 Ch. of Christ	6	4.33	3.14	35.67	5.32	17.17	3.82	3.66	.9880	63.00	23.22
4 Lutheran	6	2.50	2.51	35.33	5.01	19.83	6.99	3.48	.6219	49.67	25.11
5 Presb.	16	3.44	2.58	35.00	5.79	19.19	5.68	3.51	.4543	63.25	12.15
6 Cong.	36	4.36	4.45	37.17	5.24	18.89	5.07	3.43	.6609	62.72	15.85
7 Evan. Fr. Ch.	1	.00	.	38.00	.	19.00	.	3.55	.	67.00	.
8 Non-denom	5	4.00	2.12	39.80	3.77	22.40	9.29	3.80	.8314	49.40	23.77
9 Catholic	2	7.50	2.12	35.00	9.90	19.00	4.24	3.13	.2121	34.00	32.53
10 Episcopal	34	4.24	3.97	34.29	7.36	17.62	6.17	3.45	.6964	67.35	12.27
11 Other	6	11.67	7.50	40.17	7.17	17.67	4.72	3.47	.5527	61.17	11.87
Total	192	4.48	4.53	36.53	6.57	18.73	5.75	3.47	.6660	62.81	16.23

Note. 1 = Baptist, 2 = Methodist, 3 = Church of Christ/Christian, 4 = Lutheran, 5 = Presbyterian, 6 = Congregational, 7 = Evangelical Free Church, 8 = Non-denominational, 9 = Catholic, 10 = Episcopal, 11 = Other

Table 9
Denomination Means and Standard Deviations for Conservative/Liberal Self-Ratings

		Cons/Liberal	
	N	*M*	*SD*
1 Baptist	64	3.09	1.02
2 Methodist	16	3.56	.96
3 ChOfChr/Christian	6	4.00	.89
4 Lutheran	6	3.17	.75
5 Presbyterian	16	3.94	1.00
6 Congregational	36	3.19	1.22
7 Evan. Free Church	1	2.00	.
8 Non-denom	5	2.20	1.10
9 Catholic	2	3.50	.71
10 Episcopal	34	3.79	.73
11 Other	6	4.00	.89
Total	192	3.38	1.05

Several one-way ANOVAs were conducted to examine the mean differences in conservative/liberal beliefs and in scale scores for the various religious denominations. Since some denominations had 2 or fewer records, post-hoc comparisons, which enable closer examination of the significant individual mean differences, were not possible for these ANOVAs. First, an ANOVA was conducted to explore the between denomination group difference on levels of self-identification with conservative or liberal beliefs. There was a statistically significant difference for self-rated conservativism/liberalism (1 = most conservative, 5 = most liberal) (F [10,181] = 3.184, $p < .01$). The difference between means scores was large, with an eta squared of .149 (Cohen, 1988), suggesting that there were significant mean differences for levels of self-rated conservativism/liberalism among the religious denominations. Second, an ANOVA was conducted to explore the between denomination group difference on levels of distress. There was a statistically significant difference for distress (F [10,181] = 2.264, $p < .05$). The difference between mean scores had a medium effect size (Cohen, 1988), with an eta squared of .111, suggesting that there were significant mean differences for distress among the religious denominations. Lastly, an ANOVA was conducted to explore the between denomination group difference on attitudes toward help-seeking. There was a statistically significant difference for attitudes (F [10,181] = 1.955, $p < .05$). The difference between means scores had a medium effect size (Cohen, 1988), with an eta squared of .097, suggesting that there were significant mean differences for attitudes toward help-seeking among the religious denominations. Additional ANOVAs were conducted to explore the between denomination group difference on self-stigma, caregiver role-identity, and self-compassion; these ANOVAs revealed that there was not a statistically significant difference between mean scores.

Regression Analyses

Assumptions for regressions. Data were checked for outliers, normality of distributions, linearity/collinearity, and homoscedasticity. One assumption of multiple regression is that the errors, or residuals, are normally distributed (Keith, 2015). A review of the unstandardized residuals for both research questions showed that the residuals were normally distributed. Scatterplots of standardized residuals revealed that only a few values fell outside +/− 3. Additionally, Normal P-P plots of the standardized residuals for the regression variables were conducted. These plots showed the residuals clustered around the regression line, therefore the assumption of normal distribution of errors was met.

The data were also examined for skewness and kurtosis. For most variables, skew and kurtosis were well within limits using the rule of +/− 1. The distress variable (PHQ-9), was positively skewed (1.488) and the help-seeking variable (ATPPHS), was negatively skewed (− 1.510). After running the original regression analyses, these variables were transformed in SPSS into new variables in an attempt to reduce the skewness. The resulting variables were within the rule of +/− 1 and regressions were re-run with the transformed variables. Since the results of the rerun regression analyses using the transformed variables yielded similar results as the original regressions, the original regressions are being reported on here.

Regression coefficients were examined for collinearity. There were no correlation values with $r > .7$, so it can be assumed collinearity was not present (Keith, 2015). Regarding assumptions of linearity, scatterplots revealed linear relationships between the predictor and criterion variables. To examine homoscedasticity, scatterplots were created for the standardized residuals and predicted values of the study variables and fit lines were added. These scatterplots provided evidence that the data met assumptions for homoscedasticity.

Research Question 1. To answer Research Question 1 concerning whether clergy distress, caregiver role identity, and self-compassion predicted self-stigma, a hierarchical multiple regression was used to determine if predictor variables (distress, caregiver role identity, and self-compassion) predicted the criterion variable (self-stigma) after accounting for demographic variables (age, education, denominational affiliation, and years in ministry). Using SPSS, background variables (age, education, years of service, and denominational affiliation) were entered in Block 1, distress was entered in Block 2, caregiver role identity was entered in Block 3, and self-compassion was entered in Block 4. To account for the overall effect of denominational affiliation (a categorical variable) in the regression, the denomination variable was transformed into a new, criterion scaled (continuous) variable using the SSOSH mean (Keith, 2015).

The order of variables entered into the regression was determined by previous research on clergy and other populations. After background variables were controlled for in Block 1, levels of distress were of initial interest, as the presence of distress has been linked to caregiver role identity (Siebert & Siebert, 2005) and self-compassion (Neff, 2004). The addition of caregiver role identity prior to self-compassion in the model was based on Role Identity Theory's assertions that identity influences how one sees oneself (e.g. shame, insufficiency) particularly at times of role incongruence (McCall & Simmons, 1978; Siebert & Siebert, 2005; Pooler, 2011). Furthermore, the unique variance that role identity added to self-stigma scores was of interest. Self-compassion, on the other hand, was entered last since it is defined in literature as a response to one's own suffering (Neff, 2004), it can be considered an advanced skill which requires practice, and it engages thinking patterns that might counter those of a strong caregiver role identity.

Table 10 provides the results of the first hierarchical regression to address Research Question 1. After accounting for background variables, the variable entered in the regression in Block 2 (distress) did not result in a statistically significant increase in explained variance (ΔR^2 = .001, F[1,181] = .155, p = .694). The variable entered in Block 3 (caregiver role identity) also did not result in a statistically significant increase in explained variance in self-stigma (ΔR^2 = .018, F[1,180] = 3.503, p = .063). The final variable entered into the regression equation in Block 4, self-compassion, resulted in a statistically significant increase in explained variance of self-stigma (ΔR^2 = .056, F[1,179] = 11.320, p < .01). Self-compassion accounted for an additional 6% of variance in self-stigma scores after accounting for background variables, distress, and caregiver role-identity. An examination of semi-partial (part) correlation for self-compassion (−.237) confirms that, if this model is correct, self-compassion is important in terms of the effect on self-stigma and that the magnitude of the effect is small.

Table 10
Summary of Hierarchical Regression Analysis for Research Question 1

					Change Statistics					Correlations		
Variable	*R*	R^2	Adjusted R^2	*SE*	ΔR^2	*F*	df_1	df_2	*p*	*Zero-order*	*Partial*	*Part*
Block 1	.201	.041	.019	5.638	.040	1.906	4	182	.111			
Age										.121	.085	.083
Educ.										.028	.009	.008
Yrs Svc										.127	.043	.043
Denom.										.154	.140	.138
Block 2	.203	.041	.015	5.651	.001	.155	1	181	.694			
PHQ-9										−.030	.029	.029
Block 3	.244	.059	.028	5.612	.018	3.503	1	180	.063			
CRIS										−.129	−.138	−.135
Block 4	.340	.115	.081	5.458	.056	11.320	1	179	.001			
SCS										−.161	−.244	−.237

Therefore, no confirmative answer is found for Research Question 1. Distress was not significantly correlated with self-stigma and was not predictive of self-stigma scores, so Hypothesis 1a was not supported. Caregiver role identity was negatively correlated with self-stigma and was not predictive of self-stigma scores, thus Hypothesis 1b was not supported. Thus, neither Hypothesis 1a nor 1b were supported for the predictive roles of distress and caregiver role identity. Hypothesis 1c was supported, given self-compassion's significant correlation with self-stigma and its role in predicting self-stigma scores.

Research Question 2. To answer Research Question 2 concerning whether clergy distress and self-stigma predicted attitudes toward help-seeking, a hierarchical multiple regression was used to determine if predictor variables (clergy distress and self-stigma) predicted the criterion variable (attitudes toward professional help-seeking) after accounting for demographic variables (age, education, denomination affiliation, and years in the ministry), and to test the moderating effect of self-stigma on the relationship between distress and help-seeking attitudes. The background variables (age, education, years of service, and denominational affiliation) were entered in the regression in Block 1. A criterion scaled version of denomination using the ATPPHS mean was used for the denomination variable. The centered variables for self-stigma and distress were entered in Block 2. Finally, the interaction variable (the product of self-stigma centered and distress centered) was entered in Block 3 to test Hypothesis 2b.

Decisions about the order of variables entered into the regression were again based on previous research. Background variables were controlled for in Block 1. The decision to enter distress, self-stigma, then the interaction into the regression model was based on theory that describes self-stigma as dependent upon on the presence of psychological symptoms or distress (Vogel et al., 2013), research that demonstrates distress as highly correlated with self-stigma

(Vogel et al., 2013), and research that shows self-stigma as predictive of attitudes toward help-seeking (Corrigan, 2004; Clement et al., 2015; Link et al., 2001; Ludwikowski, Vogel, & Armstrong, 2009; Vogel et al., 2006; Vogel et al., 2007; Vogel et al., 2013; Zartaloudi, 2010). Furthermore, self-stigma researchers have encouraged exploration of the moderating relationships between self-stigma and other variables, such as type of disorder and severity of symptoms (Vogel et al., 2006).

Table 11 provides the results of the hierarchical regression to address Research Question 2. Together, distress and self-stigma resulted in a statistically significant increase in explained variance in help-seeking attitudes ($\Delta R^2 = .094$, $F[2,180] = 10.647$, $p < .001$). Specifically, distress and self-stigma account for 9% of variance in attitudes toward help-seeking scores, after accounting for background variables. An examination of the semi-partial (part) correlations for Block 2 reveals that, if this model is correct, the magnitude of the effect of distress and self-stigma on attitudes toward help-seeking was medium (−.306). The interaction term entered into the regression equation in Block 3 did not result in a statistically significant increase in explained variance of help-seeking attitudes ($\Delta R^2 = .000$, $F[1,179] = .042$, $p = .838$).

Therefore, no confirmative answer is found for Research Question 2. Hypothesis 2a was partially supported, since distress was not significantly correlated with help-seeking attitudes, self-stigma was significantly correlated with help-seeking attitudes, and together these variables were predictive of help-seeking attitudes. Hypothesis 2b was not supported since the interaction between distress and self-stigma was not predictive of help-seeking attitudes, indicating that self-stigma does not moderate the relationship between distress and attitudes in this model.

Table 11
Summary of Hierarchical Regression Analysis for Research Question 2

					Change Statistics					Correlations		
Variable	*R*	R^2	Adjusted R^2	*SE*	ΔR^2	*F*	df_1	df_2	*p*	*Zero-order*	*Partial*	*Part*
Block 1	.336	.113	.093	15.457	.113	5.785	4	182	.000			
Age										−.022	−.063	−.059
Educ.										.125	.108	.102
Yrs Svc.										.036	.046	.043
Denom.										.312	.310	.307
Block 2	.455	.207	.180	14.697	.094	10.647	2	180	.000			
PHQ-9-Ctr										−.041	−.023	−.020
SSOSH-Ctr										−.331	−.325	−.306
Block 3	.455	.207	.176	14.737	.000	.042	1	179	.838			
PHQ-9 x SSOSH										.026	−.015	−.014

CHAPTER 5

Discussion

This chapter will discuss the results presented in Chapter 4 and their implications. The findings will be discussed in terms of their convergence with or divergence from previous literature and through the framework of theories informing this study. The research and practical implications of this study will also be discussed. Finally, suggestions will be made for future psychological research and limitations of this study will be addressed.

Sample Characteristics

Demographics. This sample is majority male, with high levels of education and considerably long tenures in the ministry. Nearly half of this sample reported more than 20 years served in the ministry and the majority held advanced degrees. Women in this sample tended to be younger than male clergy with less time spent in ministry, a possible reflection of the more recent trend in many denominations toward inclusion of women in ministerial roles. Age and years in the ministry, in particular, could influence responses in this study, as longevity in a clergy role and the maturity that comes with age could influence distress levels and how one copes with distress. Furthermore, since older age and increased years of service had a relationship with lower distress in this sample, and those who were older endorsed more self-compassion, it can be assumed that clergy age and length of time in the ministry are relevant characteristics to consider in understanding the psychological experiences for these clergy. Despite these sample characteristics, results also show that clergy respondents experience distress (as measured by depression symptoms) at rates similar to other clergy, they identify strongly as caregivers, and they have levels of self-compassion slightly higher than the non-clergy population.

Support utilization. This clergy sample endorsed the use of a variety of support resources, not unlike previous clergy samples (Trihub et al., 2010). The majority of this sample was married, which may suggest the increased availability of a primary support for psychological distress by way of a spouse. In fact, clergy reported a high degree of reliance upon spouses, friends, family, clergy peer groups, and spiritual resources for support of their mental wellness, with less reported utilization of professional psychological services. Nonetheless, these clergy use, or have previously used, professional psychological services at rates higher than what has been reported in prior clergy research (McMinn et al., 2005) and they had an openness toward professional help-seeking that was similar to non-clergy. These data indicate that although this sample relies more upon their private sources of social support and spirituality than they rely upon professional psychological services, their history with service utilization may influence an openness to the use of psychological services overall.

Religious characteristics of the sample. Results from this study show that the more clergy self-identified as religiously liberal the less self-stigma of help-seeking they endorsed and the more positive attitudes they held about seeking professional psychological help. Research has already established a relationship between religious beliefs and conceptualization of, and response to, mental health symptoms. For example, researchers suggested that conservative clergy may rely more on biblical sufficiency (a predominant reliance upon biblical teachings) when coping with distress and dismiss professional psychological services as inferior or unhelpful (Salwen et al., 2017). Additionally, research has demonstrated that those with conservative beliefs have stronger biases against obtaining psychological support from non-clergy outsiders (Zellmer & Anderson-Meger, 2011) and that conservative Christians may engage in more blaming attributions about mental health symptoms (Dain, 1992), which could

influence shame and help-seeking. Thus, the current findings converge with prior studies which suggest that belief style (conservative or liberal) has a relationship to how one might conceptualize their own mental health symptoms, how they internalize stigma about help-seeking for those symptoms, and how open they remain to seeking professional psychological help for those symptoms.

In another example of differences among belief systems, the various religious denominations had significantly different scores on several scales. For example, denominations differed significantly in their levels of self-identified conservative/liberal beliefs, which is unsurprising given that denominations have historically formed due to divisions and differences in doctrinal beliefs (Rhodes, 2005). Additionally, denominations differed significantly in their levels of distress and in their attitudes toward help-seeking. While low numbers in some denominational groupings prohibited follow up analyses to identify which denominations differed significantly from each other, these findings point to a general conclusion: different belief systems resulted in variations in reported distress and attitudes about seeking professional help. Although this finding warrants further research, it suggests that belief style and denominational affiliation may influence how clergy experience and report distress, and the openness with which they approach help-seeking.

Key Findings and Theoretical Implications

Self-stigma and help-seeking attitudes. A key finding from this study is that increased self-stigma of help-seeking for mental illness predicted less favorable attitudes about psychological help-seeking. This result provides further evidence of the influence of self-stigma on help-seeking attitudes that has been established in existing literature (Clement et al., 2015; Ludwikowski et al., 2009; Lannin et al., 2015; Tucker, 2013; Vogel et al., 2007; Vogel et al.,

2013; Vogel et al., 2007), reflects the social cognitive paradigm of mental illness stigma posited by Corrigan (2000), and reinforces the important role of self-stigma in help-seeking attitudes put forth by Corrigan and Watson (2002). In addition, these findings show the existence of the relationship between self-stigma and help-seeking attitudes in a population for whom this has not been previously studied. Although clergy as public leaders and spiritual guides can often be set apart as distinct from the general population by virtue of their public and sacred roles (Hileman, 2008), they too can exhibit an internal stigmatization process common in other populations: negative messages and a sense of devaluation can be internalized about mental health help-seeking and thus influence more negative attitudes about accessing professional psychological support in times of suffering.

The fact that self-stigma did not moderate the relationship between distress and attitudes toward help-seeking in this study warrants consideration. The result suggests that distress and self-stigma appear to have separate effects on help-seeking attitudes, however their effects are not made greater or less by the interaction of the two variables. Furthermore, the effect of distress on help-seeking attitudes for this sample does not depend on self-stigma. Since distress was not significantly associated with self-stigma as had been hypothesized (an issue discussed later in this chapter), the lack of a moderating relationship is unsurprising.

Self-compassion. Another important finding in this study furthers self-compassion research by showing its association with several variables of interest. First, the data demonstrate self-compassion's link with psychological wellness, as clergy with greater self-compassion were less distressed. This relationship to psychological wellness, or the absence of psychopathology, has been a common theme in self-compassion research with the general population (MacBeth & Gumley, 2012; Neff, 2003; Neff et al., 2007; Sirois et al., 2014; Terry & Leary, 2011) and has

also been established with a previous clergy sample (Barnard & Curry, 2012). Clergy who were more distressed in this sample reported less ability to maintain self-compassion in the face of suffering.

Second, this study established a relationship not-yet examined in published psychological research: a significant link between self-compassion and caregiver role identity. While greater caregiver role identity salience has been found to correlate with professional impairment, burnout, depression, and a lack of help-seeking in previous studies (Siebert & Siebert, 2005), no prior research has examined its relationship to self-compassion. The present findings show that the more clergy adhere to their identity as a caregiver, the less they report a tendency to maintain a kind, compassionate, and accepting stance toward themselves in times of suffering. Self-compassion and its correlates warrant further investigation for clergy since this study demonstrates that clergy endorse an average caregiver role identity salience that exceeds that of other helpers (Siebert & Siebert, 2005) for whom the Caregiver Role Identity Scale was originally created. Furthermore, a tendency toward strong identification with caregiving identity may be particularly instrumental in a religious, ministerial occupation, like clergy, where individuals feel divinely called and summoned to their work (Meek et al., 2003).

Third, clergy self-compassion predicted lower self-stigma. It appears, for this clergy sample, that self-compassion is related to the internalization of help-seeking stigma, a finding that echoes previous research demonstrating that self-compassion may serve as a buffer for self-stigma and may provide resilience for those experiencing mental health symptoms (Heath et al., 2016). This finding also further supports Neff's (2009) assertion that self-compassion influences how one relates to the self and to one's own suffering. Most importantly, this finding points to self-compassion as a potentially important variable in understanding how clergy respond to their

own distress. In addition to self-stigma, increased clergy self-compassion was positively correlated with favorable help-seeking attitudes, which also positions self-compassion as a potentially important factor in clergy members' openness to receiving professional help when in distress. This openness to receiving professional services in times of suffering reflects the basic assumptions of self-compassion, which include one's ability to acknowledge suffering, to not judge it, and to see it as part of the human condition (Neff, 2004).

Clergy distress. This study revealed that, although the sample had a 13% depression prevalence, distress did not have a significant relationship to self-stigma or to attitudes about help-seeking. This was an unexpected finding that warrants further discussion. With regard to self-stigma in particular, this finding diverges from research suggesting that symptoms of mental illness result in increased self-stigma, internalized messages of being less valued and less socially accepted because of those symptoms (Corrigan, 2004; Vogel et al., 2007).

Research theoretically positions self-stigma of help-seeking for mental health symptoms as dependent on the presence of some type of symptoms. In fact, researchers define self-stigma in the following way: "Self-stigma is thought to occur when people experiencing a mental illness or seeking help self-label as someone who is socially unacceptable and in doing so internalize stereotypes, apply negative public attitudes to themselves, and suffer diminished self-esteem and self-efficacy" (Vogel et al., 2013, p. 312). Although this correlation seems implicit in theoretical discussions of self-stigma, distress and symptom measures have not consistently been used alongside self-stigma measures in the research (Vogel et al., 2007; Vogel et al., 2013), thus making comparisons between this study's results and existing literature more difficult. Among several exceptions is one study where both social stigma and distress were measured; a significant positive correlation was found between the two (Vogel et al., 2005). However, in

another study including measures of self-stigma (the SSOSH) and psychological problems, these two variables were not significantly correlated (Wade et al., 2011).

A review of instrument language in the SSOSH scale, considerations of how distress was measured in the current study, and clergy's past exposure to psychological services may provide clues to the lack of a significant correlation between distress and self-stigma. Items on the SSOSH scale use language that is both prospective and hypothetical in nature (for example, "I would feel…" and "If I could/sought/went…"). Furthermore, the SSOSH scale language does not reflect a specific type of symptom. Therefore, one possible explanation for the lack of a significant relationship between self-stigma and distress in this sample is that some clergy respondents indeed experienced self-stigma related to help-seeking, but not necessarily about help-seeking for depression symptoms they currently endorsed. Clergy may experience self-stigma related to other symptoms they experience, such as anxiety (Proeschold-Bell et al., 2015), which were not measured in this study. In that case, the presence of current distress (as measured by depression symptoms) may be less relevant to the presence of self-stigma of help seeking in this sample than other symptoms. Lastly, a majority (61.5%) of this sample reported prior or current usage of individual counseling, a percentage significantly higher than the 19% utilization of interpersonal supports (which included counseling, among other supports) that has been previously reported in clergy research (McMinn et al., 2005). It is possible that those from this sample who endorsed higher depression may have a familiarity with psychological services that lessens, rather than increases, the stigma associated with psychological help-seeking, or that other factors altogether influence the internalization of stigma. Nonetheless, the relationship between service utilization, other related variables, and self-stigma in clergy remains unknown and warrants further investigation.

Caregiver role-identity. An additional important finding from this study was also an unexpected one: a higher caregiver role identity correlated with lower self-stigma scores. In other words, the more clergy adhered to their identity as a caregiver, the less they internalized a sense of self-esteem loss, shame, and unworthiness associated with their own mental health help-seeking. Furthermore, this caregiver role identity did not predict self-stigma scores as was expected. Although the average caregiver role identity score for this clergy sample was higher than the average score reported in previous research with caregivers (Siebert & Siebert, 2005), the salience of clergy's caregiver role identity was not a significant influencer of internalized stigma about mental health symptoms and help-seeking in this study. These results diverge from theories which conceptually connect the role incongruence that accompanies heightened caregiver role identity with increased embarrassment, shame, or feelings of social scrutiny that typify internalized stigma (McCall & Simmons, 1978; Siebert & Siebert, 2005; Pooler, 2011).

Researchers have theorized that a salient caregiver role identity can magnify the tension a caregiver experiences when they find that their idealized image of themselves contradicts reality (McCall & Simmons, 1978; Siebert & Siebert, 2005). Pooler (2011) applied this theory to clergy, suggesting that role incongruence for clergy may invite fear of social scrutiny or negative evaluation and that greater caregiver role identity salience in the face of mental health symptoms may explain increased vulnerability and aversion to help-seeking in this population. It appears that caregiver role identity salience for these clergy did not relate to internalized stigma of help-seeking in the way that Role Identity Theory might suggest. This raises more questions about the nature of the relationship between caregiver role identity and self-stigma. Perhaps a stronger caregiver role identity enhances clergy's sympathy and familiarity with issues for which people seek care (like depression), thus reducing the stigma they internalize when they experience

symptoms themselves. Nonetheless, the relationship between these variables also warrants further examination.

Several additional findings related to caregiver role identity deserve attention. A strong caregiver role identity in this sample was associated with greater distress, as is consistent with previous research with other caregivers (Siebert & Siebert, 2005). The tendency to cling strongly to identities of caregiving could be occurring at the expense of clergy's own wellness. However, clergy's caregiver role identity salience was not correlated with attitudes about help-seeking, which diverged from Siebert and Siebert's research showing that social workers with strong caregiver role identity were less likely to seek help. Clergy role incongruence, or a tension between their idealized selves and their actual selves (e.g. a self that may exhibit symptoms) does not significantly influence clergy attitudes about help-seeking in this sample. Therefore, while clergy's heightened self-identification as caregivers may be associated with increased distress, its relationship to attitudes about seeking psychological help for distress may be more complex.

In summary, fears of social scrutiny or increased shame related to role incongruence for highly identified caregivers may be less of a factor in the help-seeking of clergy than Role Identity Theory might suggest, thus inviting a re-thinking of caregiver role identity in clergy. Perhaps clergy caregiving identity manifests differently than in fellow caregivers, like social workers, given the presence of variables that may typify the clergy population, such as strong religious identity and a religious calling. Additionally, clergy assume a multitude of roles. Perhaps a clergy member's assumption of alternate identities in the course of their work (e.g. teacher, preacher, and leader, to name a few) offsets the stigma they feel in relation to caregiver identity and any related role incongruence they may experience.

Implications

Practice implications. The findings of this study have significant implications for people and institutions supporting the well-being of clergy and for clinical practitioners who may encounter clergy in therapy. This study supports the relevance of organizational policies and procedures to address the levels of distress among clergy. As noted previously, job stress and depression correlate highly for clergy (Frenk et al., 2013) and clergy distress is highly linked with spiritual distress and crises of faith (Ellison et al., 2010; Guthrie & Stickley, 2008; Proeschold-Bell et al., 2013). Data from the current study support previous research (Brumley, 2016; Frenk et al., 2013; Knox et al, 2005; Proeschold-Bell et al., 2013) showing that clergy experience distress by way of depression symptoms. Congregational leaders may wish to prioritize mental health by making regular screenings and accessible therapy an organizational priority. Clinicians who treat this population, mindful of the work demands and distress clergy experience, should administer thorough screening and assessment for clergy depression, among other mental health concerns.

Furthermore, data from this study show that when clergy experience self-stigma about help-seeking, their help-seeking attitudes are less favorable. This addresses previous researchers' challenge to better understand factors that influence clergy help-seeking (Isacco et al., 2014). When supporting clergy, congregations and mental health providers alike should be mindful that even clergy – to whom many ascribe idealistic qualities of wisdom and spiritual enlightenment – can experience a sense of devaluation due to emotional and psychological difficulties and this can influence their attitudes about procuring needed professional help. Furthermore, since research has established that attitudes are a key predictor of help-seeking intentions and actual behaviors (Link et al., 2001; Vogel et al., 2005), it can be assumed that clergy attitudes about

seeking help will likely influence their eventual engagement in professional psychological services for mental health symptoms. Normalizing the ubiquity of mental illness symptoms and the common experience of stigma can aid clergy in naming their suffering, increasing awareness of self-care needs, and promoting healthy behaviors, such as psychological counseling. Additionally, the normalization by denominational and congregational leaders of mental health challenges at the beginning of a clergy member's tenure, rather than after that individual experiences symptom increase or crisis, may help reduce the stigma around help-seeking at the outset and set the example for transparency about mental health concerns.

When the stigma of help-seeking exists in clergy, it may also be powerfully addressed by codifying and making explicit the availability of professional psychological counseling through personnel policies and organization practices. Though clergy likely maintain a robust system of support (Trihub et al., 2010) and, like the clergy in this study, many may already utilize counseling, obstacles to professional psychological help-seeking – such as stigma – remain an issue of importance. For example, clergy may rely upon faith, spiritual resources, family, and peer supports to a degree that their psychological needs are sufficiently met. However, rates of distress in clergy suggest that there may be room for even further alleviation of psychological suffering in this population. If the stigma surrounding professional psychological help-seeking were reduced for clergy, perhaps there would be greater utilization of services and greater clergy mental health overall. Given the number of lives impacted by clergy, a focus on clergy mental health could translate to congregational and community health. Congregational and denominational leaders, as well as clinicians, may be instrumental – via open, candid discussion and de-stigmatizing messaging about mental health and counseling – in clergy's use of professional psychological supports and non-counseling supports alike. For those clergy already

utilizing professional psychological supports, de-stigmatizing efforts can only further affirm their wellness and self-care efforts. Bringing clergy mental health and use of psychological services into common discourse and making them less stigmatizing could have important implications for this population of caregivers, for the congregants they serve, and for broader de-stigmatization messages in society of which clergy play and important part.

Lastly, because of links of self-compassion and role identity to distress and stigma, these variables deserve attention by those invested in clergy mental health. Given the work demands of clergy, therapists and those supporting clergy should be mindful of how internalized stigma about help-seeking is related to clergy members' abilities to be gentle with themselves at times of suffering. Furthermore, even though this study did not find links between caregiver role identity and self-stigma, practitioners and researchers alike should be mindful of caregiver identity as a potentially important piece of clergy identity and as a potential factor in distress and self-compassion practices. Moreover, it should not be assumed that by virtue of their theological training and occupational choice clergy excel at exercising compassion for themselves. Like many other caregivers who experience distress, clergy may benefit from professional development and vocational enrichment aimed at fostering the six tenets of self-compassion: self-kindness, lack of self-judgment, acknowledgement of suffering as universal, reduced isolation, mindful awareness, and a focus on reducing over-identification with emotions (Neff, 2003). Building increased reservoirs of self-compassion and fostering self-compassionate behaviors could impact levels of distress among clergy, offset the role incongruence characteristic of a salient caregiver role identity, and positively influence their willingness to seek professional psychological support when it is needed.

Future Research. Since clergy distress may present in a variety of ways, future research

on clergy help-seeking attitudes and behaviors may benefit from capturing the breadth of clergy well-being through use of additional measures. For example, future research could use measures of psychological well-being, anxiety, life satisfaction, and spiritual well-being (Proeschold-Bell et al., 2013) to more fully capture clergy distress. Additionally, since higher caregiver role identity and lower self-compassion were significantly associated with increased clergy distress, research exploring additional correlates of these constructs may aid in better understanding and serving this population. For example, measurement of clergy isolation or levels of mindfulness may be informative. Further, an examination of caregiver role-identity's potential correlation with self-stigma in other caregiving populations (e.g. social workers, counselors, psychologists) and alongside other related constructs (e.g. public stigma and self-esteem) would also increase insight into the relevance of Role Identity Theory in understanding help-seeking stigma in caregivers.

Additionally, a majority of this sample reported utilization of individual counseling, which is indicative of open attitudes toward psychological counseling as a means of self-care, and notably higher than rates of utilization for this population found in other research. A better understanding of how clergy self-stigma and clergy's use of professional counseling services correlates with age, education, denomination, conservative/liberal beliefs, personality, and other background variables could be useful. Furthermore, future research on clergy well-being and mental health may wish to collect data on professional psychological service utilization to establish more robust norms. A trend may be growing toward the usage of professional psychological services in this population, or there may be samples of clergy for whom this usage is more common. When the self-stigma of help-seeking does occur in clergy, researcher's may wish to examine its possible correlates (such as self-esteem and shame) to better understand self-

stigma in clergy and how it relates to help-seeking attitudes and behaviors.

This study examined a few of many potential factors that could relate to help-seeking attitudes. Therefore, it bears mentioning that clergy may avoid psychological services for reasons unrelated to stigma and for reasons unexamined in this study, such as personal preference or satisfaction with other coping methods. Given ongoing research that confirms rates of clergy distress, however, future studies should continue to examine clergy distress alongside their various means of coping, particularly how clergy types of coping may align with their unique needs and preferences.

Lastly, it is unknown how current or past utilization of professional psychological services relates to reported self-stigma or attitudes about help-seeking in clergy and to what extent the psychological services that clergy do receive sufficiently address their needs. Future research may benefit from examination of how clergy's current or past engagement in professional psychological services relates to internalized stigma about help-seeking. Along these lines, research may be warranted on the extent to which professional psychological service providers incorporate the unique psychological and spiritual needs of religious leaders into their counseling approaches and how this relates to clergy attitudes about seeking professional psychological help. Provision of culturally sensitive services to specialized populations, like clergy, honors a broader call among psychological and other mental health practitioners to honor a variety of multicultural identities (American Psychological Association, 2017) and to incorporate spirituality when conceptualizing total health and wellness for those served (Canda & Furman, 2009). Services that acknowledge the dynamic interplay of occupational demands and role-expectations alongside the centrality of religious and spiritual beliefs for clergy may help to further demonstrate mental health providers' cultural competence, increase clergy's

openness to professional psychological services, and better address clergy mental health needs.

Limitations

One limitation of this study is the generalizability of findings. Respondents included 192 clergy from 11 denominations, representing 7 reported ethnicities. There remain many denominations of clergy and other spiritual leaders who were not represented in this sample. Furthermore, non-White ethnicities are under-represented. Therefore, findings cannot be generalized to all clergy nor to individuals of all backgrounds. Additionally, there were not enough participants in each denomination to allow for post-hoc analyses of between-group differences on means of the scaled measures. While mean differences were apparent between denominations, low numbers in some denominations prohibited further investigation into which groups differed significantly from each other on various measures.

The self-report nature of this study is also a limitation. Self-report measures in social science research provide opportunities to efficiently and affordably gather data from a large number of participants. However, self-report measures rely upon the honesty and introspective abilities of respondents, as well as their tendency to answer in ways that are not influenced by bias, such as social desirability (Heppner, Wampold, & Kivlighan, 2008). Knowledge of the extent to which respondents answered truthfully and in unbiased ways cannot be assured for this study. Also noteworthy is this study's exclusion of a social desirability measure, a decision based on the findings of a large clergy study by Proeschold-Bell and colleagues (2015) which showed that social desirability accounted for a low amount of variance in self-report outcomes. These researchers concluded that it may not be necessary for future research to incorporate social desirability measures into studies for the clergy population. Nonetheless, social desirability and other influencers of self-reporting remain a presumed limitation of this study.

A methodological limitation of this study is that results were correlational. Findings provide information about the relationship of variables to each other but do not enable claims about the causation between two variables (Heppner et al., 2008). Furthermore, additional factors that may influence self-stigma and attitudes toward psychological help-seeking were outside the scope of this study. Such factors could include the role of culture, prior socialization and education on mental health topics, congregational culture which does or does not embrace mental health concepts, clergy's prior mental health training, and previous exposure of clergy to de-stigmatizing messages. These, among other factors, likely influence internalized stigma about mental health issues and attitudes toward professional psychological help-seeking among clergy.

Summary and Conclusion

This study of clergy provides both confirmation of existing research and examination of variables not yet studied with this specific population. Results confirm that clergy experience distress, thus supporting the relevance of national initiatives aimed at clergy mental health and wellness. Clergy are critical first responders to the needs of their congregations and essential to the fabric of the communities they serve. Yet the demands of clergy work can pose a risk to their mental health (Proeschold-Bell et al., 2013). This study further highlights the relevance of attention to clergy mental health among researchers and mental health practitioners alike.

This study also expands upon previous qualitative research on clergy help-seeking (Besterman-Dahan et al., 2013; Isacco et al., 2014; Meek et al., 2003; Pietkiewicz & Bachryj, 2016) and psychological research on self-stigma in the general population (Corrigan, 2004; Vogel et al., 2013) by providing quantitative measurement of these constructs in clergy. It demonstrates that the relationship of self-stigma of help-seeking to attitudes about help-seeking which has been established in previous literature also exists in clergy. Clergy represent a distinct

population of caregivers who provide help to, and advise others on help-seeking. However, they are not immune to the influence of the stigma of mental illness when it comes to their own help-seeking. Clergy who experience the self-stigma of help-seeking likely also experience more negative attitudes about seeking professional psychological services.

This study also applies the theory of Caregiver Role Identity to a unique population of caregivers. The study measures this construct in a population for whom this theory had been postulated (Pooler, 2011) but for whom it had not been quantitatively studied. Data confirmed the presence of a relatively high clergy caregiver role identity salience. Caregiver role identity salience had several expected correlates, such as increased distress and reduced self-compassion, but findings also revealed that caregiver role identity may not relate to internalized stigma and attitudes toward help-seeking in ways originally hypothesized in this research.

Additionally, this study contributes to self-compassion literature by examining this construct with a population of caregivers who experience distress, and by demonstrating that lower self-compassion is correlated with increased distress, increased self-stigma, heightened caregiver role identity salience, and less favorable attitudes toward help-seeking within this clergy sample. Furthermore, it was established in this study that self-compassion predicted self-stigma of help-seeking scores in clergy. Given the popularity of self-compassion and other mindfulness-based constructs in psychological research and practice, an examination of these constructs with specialized populations is of value. Results affirm self-compassion's association with mental wellness overall and suggest that examination of its relationship to self-stigma and help-seeking would be a worthy endeavor in future research with other populations.

In closing, this study serves as an examination of stigma and help-seeking that is rooted in social justice, and as a call for the prioritization of the mental health of those on the front lines

of caregiving. Clergy, like counselors, psychologists, social workers, teachers, first responders, and many others, provide services that immeasurably enrich their lives and the lives of those they serve. In the course of their work, however, they also experience distress by virtue of demanding and psychologically taxing occupations. While suffering and psychological vulnerability are part of being ordinary and human, societal norms influence an increased idolization of presumed gurus and experts. When this occurs in high-profile caregivers, the price for being human can be high and the social scrutiny stifling. Academics (Brown, 2012; Neff, 2003) and spiritual writers (Chödrön, 1999; Nouwen, 1979; Palmer, 1999) alike suggest that it is one's brokenness that facilitates authentic human connection with others and equips one to be a compassionate healer. Any efforts made to normalize and heal, rather than stigmatize, the suffering of caregivers will do more than simply answer the social justice imperative of removing obstacles to help for those who need it (Corrigan, 2004). It will contribute to the ability of these caregivers to be more fully connected to their humanity, to be more self-compassionate in the face of suffering, and to be more effective conduits of healing for those they serve.

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Appendix A

Demographic Questionnaire

1. Please indicate your age: _____ (open-ended)
2. Marital status:
    A. Single
    B. Married
    C. Partnered but not married
    D. Separated
    E. Divorced
    F. Widowed
3. Race/ethnicity:
    A. Asian American
    B. Pacific Islander
    C. Black/African American
    D. Caucasian/White American
    E. Hispanic/Latino American
    F. Native American
    G. Other
4. Please choose the highest level of education you have obtained:
    A. High school diploma/GED
    B. Associate's degree (2-year degree)
    C. Bachelor's degree (4-year degree)
    D. Master's degree

E. Doctoral degree

5. Please indicate how long you have been a member of the clergy (serving as a minister):

   A. Less than 1 year

   B. 1-2 years

   C. 3-5 years

   D. 6-10 years

   E. 11-15 years

   F. 16-20 years

   G. Over 21 years

6. Please confirm your status:

   A. Full-time clergy member

   B. Part-time clergy member

7. When compared to other members of the clergy, how would you describe your beliefs on a scale of 1 to 5, with 1 being most conservative and 5 being most liberal?

   1 2 3 4 5

   Conservative Liberal

8. Identify the type of setting where your church is situated:

   A. Urban

   B. Suburban

   C. Rural

9. With which denomination are you affiliated?

   A. Southern Baptist Convention

   B. United Methodist Church

C. American Baptist Churches USA

D. Church of Christ

E. Evangelical Lutheran Church in America

F. National Baptist Convention

G. Assemblies of God

H. Lutheran Church-Missouri Synod

I. United Church of Christ

J. Presbyterian Church in America

K. Church of God

L. American Methodist Episcopal

M. Pentecostal

N. Non-denominational

O. Other _____

10. Members of the clergy use a wide variety of tools and resources to pursue well-being and manage the stressors of ministry. Please designate which resources you have used in the past or present to support your own thriving.

    Relationship with spouse or family YES / NO

    Relationship with friends YES / NO

    Clergy / peer support groups YES / NO

    Religious / Spiritual resources (e.g. prayer, scripture, meditation, retreat) YES / NO

    Individual counseling/therapy YES / NO

    Couples counseling/therapy YES / NO

    Group counseling/therapy YES / NO

Family counseling/therapy YES / NO

Medications to address psychological concerns (e.g. depression, anxiety) YES / NO

Substance use treatment or recovery-based support groups (e.g. AA, NA) YES / NO

Other resources to support thriving: (Please describe)

Appendix B

Patient Health Questionnaire – 9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Appendix C

Self-stigma of Seeking Help Scale

	Strongly disagree		Agree and Disagree Equally		Strongly Agree
1. I would feel inadequate if I went to a therapist for psychological help.	1	2	3	4	5
2. My self-confidence would NOT be threatened if I sought professional help.	1	2	3	4	5
3. Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
4. My self-esteem would increase if I talked to a therapist.	1	2	3	4	5
5. My view of myself would not change just because I made the choice to see a therapist.	1	2	3	4	5
6. It would make me feel inferior to ask a therapist for help.	1	2	3	4	5
7. I would feel okay about myself if I made the choice to seek professional help.	1	2	3	4	5
8. If I went to a therapist, I would be less satisfied with myself.	1	2	3	4	5
9. My self-confidence would remain the same if I sought help for a problem I could not solve.	1	2	3	4	5
10. I would feel worse about myself if I could not solve my own problems.	1	2	3	4	5

Appendix D

Caregiver Role Identity Scale

Strongly Disagree				Strongly Agree
1	2	3	4	5

1. I regularly help family members with their problems and concerns.
2. Friends frequently turn to me when they have problems or concerns.
3. Work colleagues generally turn to me when they have problems or concerns.
4. I have heard I am a natural helper or caregiver.
5. I began attending to others at an early age.
6. It is my responsibility to be helpful to my family and friends.
7. It is easier to care for others than to care for myself.
8. It is difficult to tell friends or family that I cannot help them with a problem.
9. I would characterize myself as a rescuer.
10. Being a helper or caregiver is an important part of who I am.

Appendix E

Self-Compassion Scale

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				Almost Always
1	2	3	4	5

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix F

Attitudes Toward Seeking Professional Psychological Help Scale

Almost Never			Almost Always
1	2	3	4

1. Although there are clinics for people with mental troubles, I would not have much faith in them.
2. If a good friend asked my advice about a mental problem, I might recommend that he/she see a psychiatrist/psychologist/counselor.
3. I would feel uneasy going to a psychiatrist/psychologist/counselor because of what some people would think.
4. A person with a strong character can get over mental conflicts by him/herself, and would have little need of a psychiatrist/psychologist/counselor.
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.
6. Considering the time and expense involved in psychotherapy or counseling, it would have doubtful value for a person like me.
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric/psychological treatment or counseling.
9. Emotional difficulties, like many things, tend to work out by themselves.
10. There are certain problems which should not be discussed outside of one's immediate family.
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
14. Having been a psychiatric/psychology/counseling patient is a blot on a person's life.
15. I would rather be advised by a close friend than by a psychologist/counselor, even for an emotional problem.
16. A person with an emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help.
17. I resent a person – professional trained or not – who wants to know about my personal difficulties.
18. I would want to get psychiatric/psychological/counseling attention if I was worried or upset for a long period of time.
19. The idea of talking about problems with a psychologist/counselor strikes me as a poor way to get rid of emotional conflicts.
20. Having been mentally ill carries with it a burden of shame.
21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know everything about oneself.

23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy/counseling.
24. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help.
25. At some future time I might want to have psychological counseling.
26. A person should work out his/her own problems; getting psychological counseling would be a last resort.
27. Had I received treatment in a mental hospital, I would not feel that it out to be "covered up."
28. If I thought I needed psychiatric/psychological/counseling help, I would get it no matter who knew about it.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen/clergywomen.

Appendix G

Recruitment Letter

Dear Clergy member:

My name is Kristen Sager and I am a doctoral candidate in Counseling Psychology at the University of Kansas. For my dissertation project, I am conducting a study focused on clergy well-being and thriving. In particular, I am examining clergy coping resources, distress levels, stigma, role identity, self-compassion, and help-seeking attitudes. I am seeking participation by full-time clergy members.

Your participation in the study is voluntary and you may withdraw your participation at any time by exiting the survey. No identifying information will be collected, and all responses will be kept confidential. Potential risks associated with participation are minimal.

If you are willing to participate, please click on the link below. The survey should take about 30 minutes to complete.

<Qualtrics link pasted here>

If you have any questions or concerns, feel free to contact me at kristen.sager@ku.edu, or my doctoral advisor, Changming Duan, at duanc@ku.edu. This research has been approved by the University of Kansas Institutional Review Board (will include number upon approval).

Thank you for your time and consideration.

Warm regards,

Kristen Sager, MSW

Doctoral Candidate, Counseling Psychology

University of Kansas